Registered at the G.P.O., Sydney, for Transmission by Post as a Newspaper. Published Weekly. Price 1s.

THE

MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—11TH YEAR. SYDNEY: SATURDAY, JANUARY 5, 1924. No. 1.

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SOME NOTES ON ECTOPIC GESTATION.[1]

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IN a gynæcological ward in which on an average about twenty-five beds are occupied, there must be some clinical work worth recording. That is my excuse for bringing these notes before you.

To get the full value of such work it requires a skilled clinician with an aptitude for taking careful and minutes notes on some fixed scheme. That skill and aptitude I cannot claim, consequently opinions that may be expressed, are formed in the main more from the general survey of the cases than from minute detail.

The first difficulty was to find a subject that would be of general value and not of interest to only a few. I chose ectopic gestation as it comes into the practice of the surgeon, physician and general practitioner.

Historical.

One can find the history of the condition so well given in most of the text-books, that I will not go into it, but will give a few extracts that I think are of interest.

In Hamilton's "Midwifery" published in 1789 he says:

> Instances sometimes—though rarely—occur of fœtuses remaining in the ovarium or tubes or where the fœtus grows to the outer side of the womb, or to some of the neighbouring parts. These fœtuses are generally of small size and die at an early period. They are often discharged by abscesses through the skin of the belly or by stool.

In Baudelocque's "Midwifery" translated by Heath and published in 1790, there is a great deal more about extra-uterine pregnancy. In Section II. he says:

> It is extremely rare that an extra-uterine pregnancy arrives at its full period so happily as a common one, especially so where the child is in the tube, as the sides of that canal being very thin, cannot expand sufficiently to contain it and besides does not receive blood enough to furnish what is necessary for the development of the child and the placenta. The greater part of the fœtuses found in the tubes or ovaria have not been larger than those of three or four months usually are, and often still smaller.

He then mentions some exceptions and continues:

> It seems notwithstanding these exceptions, that the tube cannot be developed beyond what is necessary to contain a child of three or four months. It is at that epoch that it usually perishes, after which it withers or putrifies. Sometimes also the tube bursts and lets it fall into the cavity of the abdomen, where it soon undergoes the same alteration. The fate of the woman in all these cases is different, according to that which affects the child. She may live a long time, even without having her health

[1] Read at a meeting of the Queensland Branch of the British Medical Association on October 5, 1923.

much injured, when it withers or in some measure putrifies but she soon feels the effects of its putrefaction when that takes place.

In a later paragraph he says:

If the efforts of Nature alone have sometimes saved the life of the mother in extra-uterine pregnancies, though at the same time exposing her to a thousand dangers, or at other times she has been entirely indebted for that advantage to the assistance of art, how many evils might that assistance, always too late for the child and often for the mother, have prevented, if surgeons had been less timid in proposing it, or if they had met with women sufficiently courageous to submit to it in time. The opening of the abdomen and the tube, according to circumstances, at the same time that it would have snatched some of these women from certain death, might have saved many of these children conceived out of the proper place.

There are two interesting points in these extracts. In the first place neither of these authors appears to recognize the early ruptured ectopic pregnancy with the internal hæmorrhage which appears commonest today and secondly there is the strong advice of Baudelocque in 1790 to operate and even open the tube.

In an American translation of Cazeaux and Tarnier's book on midwifery, published in 1884, the authors go very fully into the subject of extra-uterine pregnancy and point out that the fœtus does not generally survive after the fourth or fifth month and that the condition more frequently terminates by rupture of the cyst at an early age, causing hæmorrhage and death of the mother. In this book we find under the heading of treatment the following:

It is evident that no operation could be attempted in the earlier months of pregnancy, even if we should be fortunate enough to ascertain with certainty that the ovule was not developed in the uterus. Frequent copious bleedings should be resorted to in such cases for the double purpose of causing the death of the fœtus and of preventing too great a determination of blood towards the point at which the ovum is being developed.

Venesection practised within the limits authorized by the general health of the patient, will be more indicated here as its unfavourable influence on the child's life is not to be dreaded since its death is the most fortunate event that could occur.

The latter result may be obtained by passing electric shocks through the cyst. Dr. Allan, of Philadelphia, succeeded twice in causing the death of the fœtus by means of the faradic current.

Mention is also made of a case reported by Dr. T. G. Thomas in the *New York Medical Journal*, June, 1875, in which he had operated successfully on a tubal pregnancy of three months by cutting into the sac through the vaginal walls by means of a platinum knife of the galvano-caustic battery.

Coming to Eden and Lockyer's new "System of Gynæcology" we find a complete change, for now the frequency of early rupture and hæmorrhage is fully recognized.

The majority of cases of tubal pregnancy come under observation at the time of rupture or abortion and this is usually at some period between the fourth and twelfth week. According to Whitridge Williams, W. W. Harbart in 1849, was the first to suggest laparotomy for the purpose of arresting hæmorrhage from ruptured tubal pregnancy and Stephen Rogers wrote in 1867: "The peritoneal cavity must be opened and the bleeding vessels ligated."

Parry in his work on extra-uterine gestation published in 1876, argued the necessity of operation, but Lawson Tait in 1883 was the first to adopt the suggestion and to operate successfully for this condition.

When the symptoms of hæmorrhage are unmistakable and the patient's life is in great danger, abdominal section should be performed at once and the ordinary rule of surgery followed to cut down upon the bleeding point.

After giving statistics of cases operated on immediately and those treated without operations, G. F. Blacker states:

In the face of these results and in view of the fact that from time to time patients do die from hæmorrhage as a result of the rupture of a gravid tube, it is difficult to recognize any sound arguments for deferring operation.

I would like to put this in stronger language and say that wherever the history and symptoms give rise to a reasonable doubt that there may be an ectopic gestation an exploratory laparotomy should be performed and I think the following notes on cases will bear me out.

It will not always be an ectopic pregnancy that we find, frequently it will be an inflamed tube or one containing pus, but in either case the operation is justified and if as we occasionally find there is nothing abnormal, the patient nowadays suffers little or no ill-effects.

Case Records.

From January, 1921, to the end of August this year twenty-three patients suffering from ectopic gestation have been admitted to the Brisbane Hospital. There were three deaths. The first patient was admitted at 3.15 p.m. on May 5, 1923, in a very collapsed condition, she was operated on and the abdomen was found to be full of clot. She did not rally and died at 5 p.m. on the same afternoon. The second patient was admitted at 11.30 p.m. in a collapsed condition and died within an hour. The third patient I will deal with later.

When a ruptured ectopic pregnancy is mentioned, we immediately think of the classical description. A woman who may be pregnant and is generally a day or two overdue with her menstrual period, is suddenly attacked with acute pain in the lower portion of the abdomen, she vomits, feels faint or faints, becomes blanched and collapses. Such a case is so evidently serious that she is sent to hospital or operated on at once.

But even these cases are not always clear, for three patients of the series were admitted to surgical wards.

Case I.—A.B., *ætatis* thirty-three years, was admitted on February 17, 1922. Her pulse rate was 152. She had a child eleven months old. She had been taken ill suddenly at 6 a.m. with pain and vomiting and she was tender all over the abdomen. Vaginal examination revealed the lateral fornices to be tender and the posterior fornix to be boggy. On operation the abdomen was found to be full of blood and clot, the right tube was bleeding.

Case II.—C.D., *ætatis* thirty-three years, was admitted on January 20, 1923. She had complained of pain in her abdomen for some days, but was seized with acute pain about 2 p.m.. The pain doubled her up, but she did not vomit. A

provisional diagnosis of appendicitis or tubal inflammation was made. At the operation there was a ruptured right tube and free blood and clot.

Case III.—E.F., *ætatis* forty years, had a temperature of 37.8° C. (100° F.) on admission. Her pulse rate was one hundred and forty-two in the minute. She complained of severe pain in the right side for the previous one and a half days. It had come on suddenly and had doubled her up. The pain would start in the right side and shoot across the abdomen and up to the shoulders. With pain she had "straining in the front passage." Vaginal examination revealed tenderness in the right fornix. A provisional diagnosis of acute appendicitis was made. On operation the abdomen was found to be full of clot and blood and the right tube with a gestation sac was removed.

These three cases show that even the acute symptoms of a ruptured ectopic pregnancy with considerable hæmorrhage do not always follow the classical description. This is not, of course, important as they are undoubtedly acute conditions which call for immediate operation.

Of the remaining eighteen patients eleven were operated on immediately or within twenty-four hours. They were either suffering from undoubted ectopic pregnancies or at least acute abdominal conditions which called for operative interference. There is only one of these to whom I wish to draw attention.

G.H., *ætatis* twenty-three years, had been in hospital three weeks previously with a miscarriage. She was not curetted and as the pain and bleeding ceased she had been discharged. She was admitted at 1.40 p.m. with typical symptoms of a ruptured ectopic pregnancy and operated on. The abdomen was found to be full of blood and clot, the right tube had ruptured.

I think this is the patient who collapsed in the church just after the completion of the wedding ceremony.

This leaves seven cases and it is from these cases in particular that I wish to point my moral and adorn my tale.

I.J., *ætatis* thirty-one years, was admitted on February 15, 1922. Her last menstrual period had occurred on January 30, 1922. She had been bleeding from the vagina for about twelve days. No bleeding had occurred for three days after her last period. It had then commenced and had been accompanied by pain. On examination slight abdominal tenderness in the pelvic region was found. On vaginal examination the fornices were not tender and no swelling was felt. A diagnosis of miscarriage was made and the uterus was curetted on February 20, 1922. As the symptoms did not clear up, her abdomen was opened on February 27. A pelvic hæmotocele with a ruptured left tube was found.

K.L., *ætatis* twenty-six years, was admitted on January 14, 1922, complaining of pain in the lower half of the abdomen. Pains came on suddenly. She had slight scalding on micturition. Tenderness was present in the left ovarian region. The patient had not vomited. The last menstrual period had occurred some weeks previously. She had one child seven years of age. No vaginal discharge was present. A pelvic examination was made by Dr. Meyers.

On January 17, 1922, she was again examined by the resident medical officer who noticed that the uterus was anteverted and enlarged. Tenderness was present in all fornices. Nothing abnormal was felt except an enlarged uterus. Slight laceration of the cervix was present. Her condition was diagnosed as a threatened miscarriage. She improved. I examined her on January 18 and she was discharged on the following day. She was re-admitted on February 11, 1922, with a normal temperature and pulse rate of eighty-four. She stated that she had miscarried several days before and had been bleeding and passing clots since. On pelvic examination the external *os uteri* was found to be patulous. It admitted one finger. The abdomen was semi-rigid. On February 12, 1922, the uterus was curetted at 10.45 a.m.. The pulse was good after operation and the colour was good. At 12.50 p.m. she was reported as being in a weak state with a feeble pulse. The abdomen was becoming distended and tender. The patient had recovered from the anæsthetic. The condition was reported to me and arrangements were made for immediate operation, but she died at 1.45 p.m.. At the curettage decidual tissue had been removed. The question arose at once as to whether this was a ruptured ectopic pregnancy or whether the uterus had been perforated.

We were able to perform a *post mortem* examination and the right tube was found ruptured with a pregnancy of about three months' duration.

Whether this patient actually miscarried between her two periods in hospital and was suffering from intra- and extra-uterine pregnancy or whether the report of a miscarriage out of hospital was not true it is, of course, impossible to say. She was seen and examined by Dr. Meyers and myself and the resident medical officer with no suspicion of an ectopic pregnancy.

M.N., *ætatis* twenty-three years, was admitted on January 8, 1923. The pulse rate was eighty-four. She complained of "pain in stomach and bearing down into back passage" for one month. The last monthly period had occurred on December 17, 1922. She had two children, aged respectively one year and ten months and eight months. On examination the abdomen was found to move with respiration. Tenderness was present in both right and left iliac fossæ and there was dulness in the flank.

Vaginal examination revealed a mass in the right fornix; the uterus was enlarged. A provisional diagnosis of ectopic pregnancy was made. Operation was performed on January 11, 1923. Salpingitis and a large quantity of blood clots were found. A ruptured right tube was removed.

O.P., *ætatis* twenty-three years, was admitted on April 4, 1923. The temperature was 37.8° C. (100° F.) and the pulse rate was one hundred. She complained of vaginal bleeding of about six weeks' duration. She said that she had not menstruated for about six weeks. She had had slight pain in the left side. On examination nothing abnormal was found. A provisional diagnosis of early abortion was made. The uterus was curetted on April 24, 1923, with a blunt curette and only a little tissue came away. Temperature remained about 37.8° C. till May 2, 1923, when it rose to 40° C. (104° F.). The abdomen was opened. A large amount of foul-smelling blood and clot was found. The right tube was found ruptured near the uterus and removed. A drain was inserted and the patient was discharged on May 30, 1923.

Q.R., *ætatis* twenty-six years, was admitted on April 23, 1923. Her temperature was normal and the pulse rate was eighty-four. She had been bleeding for six weeks. She complained of a lot of pain in the left side. On examination nothing was found except tenderness in the right fornix. The abdomen was opened on April 26, 1923, and the right tube was found to be the seat of a pregnancy and removed.

S.T., *ætatis* twenty-six years, was admitted on June 27, 1923. The temperature was normal and the pulse rate was seventy-two. She had been bleeding for three weeks. She had experienced severe pain on four occasions during three weeks in the lower portion of the abdomen. The attacks had lasted about one hour and she had vomited during one of the attacks. Vaginal examination revealed a dilated external *os uteri*. The uterus was enlarged, but not tender. The fornices were clear. A provisional diagnosis of threatened abortion was made.

The uterus was curetted on July 2, 1923, and as some doubt was raised by the examination under the anæsthetic the abdomen was opened. There was a hæmatocele in the pouch of Douglas and a hæmato-salpinx on the right side which was removed.

U.V., *ætatis* thirty-two years, was admitted on August 3, 1923. The temperature was normal and the pulse rate eighty-two. She complained of pain in the right side of the lower part of the abdomen. She had fainted twice with pain. She had not menstruated for two months. The uterus was fixed and very tender.

I operated on August 7, 1923, and found the abdomen full of blood and clot. The clot was organized and adherent to the intestines. The right tube with a gestation was removed.

Besides these cases I have, during the last two years, opened several abdomens and have found masses of adhesions around the tube and ovary. Sometimes pus has been present and sometimes not. Although it is not possible to say with certainty, I have felt that the adhesions were the after effects of a pelvic hæmatocele from a tubal abortion. Again, twice in opening a mass in the pouch of Douglas by a posterior colpotomy blood clot has been evacuated. So that it has been more and more borne in on me that there must be many women with tubal abortion or rupture who are treated for early miscarriages or salpingitis and recover, but a mass of adhesions is left with serious after effects. Further I have concluded that a certain number of the cases of pelvic abscess which are ascribed to pus tubes, are really abscesses following pelvic hæmatocele.

One of the problems that meet a surgeon in a gynæcological ward is the treatment of inflamed tubes and pus tubes. For a time I was of the opinion that every opportunity should be given by rest and palliative treatment for these cases to resolve and the routine treatment was to defer operation unless the inflammation became general. After four years' experience, however, I have reviewed this opinion and think the abdomens of these patients should be opened and the tube removed.

A tube which might recover, may occasionally be removed (and some marvellous recoveries are seen), but more patients will certainly be saved from general peritonitis or even extensive pelvic peritonitis.

If that opinion is held it allows a surgeon to operate more freely and I think it will be found that a proportion of these supposed pus tubes are ectopic pregnancies. In this way delay and risk will be saved. This is borne out by the case histories which I have quoted.

Signs and Symptoms.

In regard to pain if the rupture is small or in a tubal abortion, the pain as in the histories quoted, may be slight and, though generally pelvic, may be referred to other parts of the abdomen. Pain down the thigh is often complained of in tubal inflammation and pregnancy.

Tenderness on vaginal examination again is relative as shown in the histories. The extreme tenderness on palpation of the external *os uteri* is a sign about which I have not been able to satisfy myself. I think it is elicited with all acute pelvic conditions, especially when the tubes are affected.

In the collapsed patients the temperature is of course low, but in the chronic form, if I may use the term, it may vary for some days around 38° C. and make the surgeon to suspect the presence of an inflamed tube.

In the acute cases as in any hæmorrhage the pulse is generally rapid, but I would lay stress on two instances I have seen. In these the patient was collapsed, the abdomen was found to be full of blood and clot and, although the pulse was imperceptible at the wrist, the rate of the heart beat was seventy-two in the minute. The menstrual history may be a help, but cannot be relied on, especially in unmarried women.

Time of Operation.

In the acute stages operation should be undertaken at once. I cannot see that anything is to be gained by waiting for the patient to rally. A few patients do improve, but as it is impossible to determine the amount of damage done, valuable time and life may be lost. The patients who will rally, will be less seriously affected and will certainly stand the operation.

Saline infusion and blood transfusion should, of course, be used if required, but no time should be wasted. I wish to reiterate that where there is a reasonable doubt that there may be an ectopic pregnancy an exploratory laparotomy should be performed.

Type of Operation.

I have always removed the whole tube, *id est* not just excised the ruptured portion, principally because it is simpler and quicker and time is the essence of success. Certainly a late honorary surgeon at the Brisbane Hospital was right when he said: "Surgery is not a contemplative art."

In regard to this point of removal of the free end of the tube, Dr. D. A. Cameron reported to me an interesting case which he saw some weeks ago, when he removed a cystic ovary. The patient had been operated on some years ago in the Brisbane Hospital and a ruptured ectopic pregnancy had been removed. At the recent operation there was a question of the presence of ectopic gestation and it was found that blood was oozing from the fimbriated end of the ligated tube, there being blood and scum free in the abdominal cavity.

If the fertilized ovum moves about in the abdominal cavity as is generally recognized, there can be no reason why it should not get into the free end of an occluded tube and so cause an ectopic gestation.

Conclusion.

In closing my paper I would like to refer to one other case worth reporting of a patient on whom I operated soon after my return. She had been operated on by Dr. McKenna about a year previously for an ectopic gestation and I operated for an ectopic gestation of the other tube. She had had one previous pregnancy and had given birth to triplets.

I must thank Drs. Allan, Anderson and Lilly for permission to use their cases.

AN ADDRESS TO STUDENTS.[1]

By WILLIAM CHISHOLM, M.D.,
Senior Consulting Surgeon, Sydney Hospital.

I WOULD like to express to my old friends and former colleagues on the staff of the Sydney Hospital. and on the Board of Medical Studies how much I appreciate the kindly though which prompted them to invite me to deliver the annual inaugural address on this occasion.

The time may not be inappropriate seeing that by a happy coincidence a son of Angel Money, an old fellow-student of mine at University College Hospital, London, has after having served with distinction in the Great War, recently gained academic distinction in the final examinations at the University and that Grafton Elliott Smith, one of your earlier graduates now with a European reputation has been appointed to the Chair of Anatomy in my old Medical School.

On behalf then of the Directors and the Board of Clinical Studies I have pleasure in welcoming you to the wards of the Sydney Hospital. May the time you spend here be for each of you a happy one wherein you will lay the foundations of an honourable and successful career!

It is only fitting that I should first express our regret at the death of Sir Herbert Maitland and our sense of the loss the hospital and its clinical school have sustained by the sudden taking-off of the Senior Surgeon and Lecturer in Clinical Surgery whose services are commemorated by this tablet.

The Board, however, is fortunate in securing as his successor one of our ablest graduates in the person of Dr. Corlette; you can be well assured that the reputation of the hospital as a clinical school so far as its surgical side is concerned will be fully maintained.

I would also refer with regret to the death of another former teacher, Dr. George Edward Rennie, who after a very notable career at the Sydney University and University College, London, returned to Sydney and was for some time Lecturer in Medicine at the University and for many years Lecturer in Clinical Medicine at the Royal Prince Alfred Hospital. I cannot do better than add to the many tributes to his memory the simple statement made at the graveside by one of his former pupils, which will doubtless find an echo in the hearts of many others: "He was a fine teacher and he had an immense influence for good over my own life."

By your presence here we can assume that you wish to learn the science and art of medicine. You have already studied the structure and functions of the human body in health and are now to learn how they are modified or destroyed by disease. You will get to realize that disease is not an entity to be driven out or some demon to be exorcised, but often only some disordered function or faulty habit to be corrected. One often hears lectures spoken of as though they were a waste of time. No doubt there is not in many subjects the same need for lectures now as formerly, owing to the excellence of modern text-books; many of us can look back on time wasted listening for instance to lectures on anatomy before working in the dissecting room. But in your clinical work they are indispensable. Much, of course, depends upon the manner in which they are given and the aptitude of the lecturer to fasten his knowledge in the student's mind. A lecturer may see you do not understand his teaching and he can go over his subject again in different words and you can always appeal to him afterwards to clear up any obscure points.

Do not waste you time for you will not be able to make up for lost opportunities and be not too much obsessed with the dread of examinations ahead, but try day by day to add to your knowledge, for even when you have satisfied your examiners in "the final" you will have to submit to more trying ordeals at the hands of your patients and their friends. Cultivate your faculty of observation. There is more to be learnt from the manner of respiration than the mere number of inspirations in a minute; so too the quality of a pulse will often tell you more than its frequency and you can learn much from the expression of a countenance.

It will be well always to bear in mind that a hospital ward is a place of suffering where you may learn to admire the patience with which much of it is borne and, though many a patient may have what seems to you a trivial complaint, remember that it is not the disease but a being of like parts and passions as yourself that you are treating and you may not know the deadening influence of anxiety on some breadwinner laid temporarily aside by illness.

In this community it is almost superfluous to urge the advisability of combining a certain amount of play with your work. It is better to take an active part in your games than to be a mere looker-on.

I would impress upon you that neither the reputation of a medical school nor the ability of its teachers will of themselves avail to make you successful practitioners of medicine apart from your own efforts and steady continuous application to your work. Should you be idle and incompetent, it might be worth your while to realize that our numbers, great as they are, are not yet sufficient to tempt vote-catching politicians to come to your aid with the promise of a "right to patients" or "a basic income."

I must resist the tendency of age to go back to times that are past or I could perhaps entertain you with a description of things as they were when I first entered the wards of a hospital as you are now about to do. Those were times when the surgical theatre had its wooden tables and the surgeon operated in an old frock coat worn out with service in the consulting room and often bearing evidence of previous sanguinary engagements on the operating table, not to mention the dust which had

[1] Delivered to the students of the Sydney Hospital in the Maitland Theatre on September 19, 1923.

accumulated on it during its weeks' repose on a peg in the surgeon's room. What a contrast to the surgeon of today, clothed in spotless white and armed literally *cap à pie* for his warfare against innumerable though invisible foes! I could tell you of a most lovable and capable surgeon who once said: "I'm afraid I have killed this poor fellow," because in performing the operation of lumbar colotomy he had inadvertently opened the peritoneal cavity, a thing seldom deliberately done at that time. However, he did not kill the patient and the operation was quite a success.

I could refer to old note books where it is stated that malaria is due to some peculiar emanation from the soil and to the teaching following on this erroneous belief. Again to where our old teacher Dr. (afterwards Sir) Russell Reynolds relates that when he himself was a clinical clerk in University College Hospital, every one was bled, whether he had pneumonia, apoplexy, a compound fracture or a fit. The microscope was there and about it one of the eminent professors at that time once said to him: "If anything is so small that it requires a microscope to see it, I am quite sure it can't be of any great importance."

But the old temple of medicine built up on various fanciful conceptions has fallen and in its place is being erected one founded on the teachings of pure science; and you have succeeded to a rich inheritance which like other great possessions carries great responsibilities with it. Those who have to arrange the course of medical education, have their difficulties correspondingly increased, for with the great improvement and refinements in diagnosis made possible through the labours of many patient workers in the various laboratories it is difficult so to arrange the period of study as to make it possible to turn out practitioners fully qualified to treat the sick and at the same time possessing at least a sound knowledge of the facts underlying the various ancillary branches to one or other which it is often necessary to refer in the course of their practice, if they are to do the best in the interest of their patients. But I must confess that these recent advances have extended into regions far beyond my depth and I must be content to leave you in the hands of your more competent teachers.

Suppose then that the happy day has come which entitles you to write certain letters after your name and to be enrolled on the list of duly qualified practitioners, what is your outlook? First it is essential in the interest of your future patients, if not for your own peace of mind, that you should spend at least a year filling various posts in a recognized public hospital. That there is a difficulty here, in that the applicants for these positions are more numerous than the positions to be filled, unfortunately cannot alter this fact. Some of you no doubt look forward to the day when you will be attached to the honorary staff of some hospital and become teachers yourselves, so it is well to study the methods of those you find the most attractive teachers, so that you may prove worthy successors. Others again may be attracted to the preventive and more scientific aspects of medicine and I hope I may be addressing, if not an embryo Pasteur or Lister, perhaps some who will be worthy to rank with Manson, Ronald Ross or Banting.

The large majority of you will probably become general practitioners. Do not despise this humbler rank, for it has been well said that the general practitioner is the backbone of the profession.

Should you decide to practise in the country, you will do well to give extra time to some of the special departments of the hospital so that you may be able to deal satisfactorily, if only temporarily, with the various emergencies with which you may be confronted. The motor car has done much to lessen the responsibilities and anxieties of country practice and things will be much better when those responsible for the construction and maintenance of our streets and roads are more efficient at their job. Even now it is possible in many districts to convey in comparative comfort patients in a serious condition to some centre where there are greater facilities for treatment; a marked contrast to the time when a friend still living had to be taken with a broken thigh in a waggonette a distance of one hundred miles to the Beechworth Hospital.

Great responsibilities will be yours in the performance of your duties and at first you may find them bear heavily upon you. You may have long night journeys in the bush to attend the wife of some lonely settler, fearful because her hour has come for a child to be born into the world, or to close the eyes of some sick stock-rider, never again

> To wheel the wild scrub cattle at the yard.

But a country practice has many attractions, it brings you into contact with some of the finest Australians—

> The stalwart men who are stoutly fighting
> With the heat and drought and the dust-storm smiting.

You may be the welcome guest in their homes, the sharer of their simple pleasures, the helper and consoler in their sorrows; and like all our members you will have opportunities for doing many little acts of kindness and of love not all of which will be unremembered even in an oft-times forgetful and ungrateful world.

This is the day of preventive medicine and governments are looking more and more to the profession for help and guidance in the many different problems affecting the material and social well-being of the community. But it may fairly be asked if the tendency of much both of our legislation and our philanthropy is not to weaken the sense of individual responsibility and to teach people to think more of their rights than of their duties to the State.

Questions, such as the treatment of consumption, the prevention of occupational diseases, prohibition, the control of venereal diseases, birth control, the treatment of mental defectives and segregation of the unfit, are some of those on which you will be expected to have definite and helpful views.

As to so-called spiritual healing which has been rather warmly discussed here. Is it worth while

to cross swords over matters of this kind where appeal is made as much to the emotions as to the intellect and where it is always very difficult for one side to convince the other? Truth will in the end prevail. Meantime may we not leave to its supporters "their early heaven, their happy views," even though experience teaches us that Shakespeare had true insight when he made one of his characters declare:

> Our remedies oft in ourselves do lie,
> Which we ascribe to heaven.

He would be a rash man who would presume to guide you through the maze of all these perplexing questions, and I shall only venture to touch on some points which may help you to form your own opinions.

The incidence of tuberculosis would be much less if instead of people crowding into our one big congested city, they showed more of the spirit of our early pioneers and ventured out to fill some of our empty spaces. Not only would the amount of tuberculous disease but also the evils of intemperance and venereal disease be much lessened if more fresh air and sunlight were admitted into many of our dwellings. Something has been done in the way of sanatorium treatment, but Dr. Camac Wilkinson, a former lecturer on medicine at the University and a recognized authority on tuberculosis, is of opinion that work done during recent years seems to prove that Professor Koch's method will largely displace sanatoria. It is hoped that at the Congress in Melbourne much information will be forthcoming in connexion with industrial hygiene.

With regard to prohibition I suppose doctors have better opportunities than most people of judging the effects of the use as well as the abuse of alcoholic liquors; and unless my observation has been at fault an overwhelming majority seem to agree with Iago—scoundrel though he was—that: "Good wine is a good familiar creature, if it be well used," and not abused as by Cassio so as "to steal away his brains." No doubt there are some prohibitionists in the medical profession; there is no reason why a man should not be a total abstainer if he so desires, but there is no justification for him to force his views as to the necessity for it on other people who enjoy a glass of wine or spirits, and feel that it adds to their well-being and enjoyment of life. What is the value of statistics as to the number of convictions for drunkenness furnished by persons anxious to prove by this means the benefit of prohibition, when people can get more blind drunk with vile liquor in their own homes than they would ever venture to do when they have to find their way home from the saloons?

Every prohibitive law that is passed, is a confession of failure, for it admits that hope is abandoned of the evil in question being remedied by the good sense and decency of public opinion. Surely the object of these would-be reformers would meet with greater support and be justified by more beneficial results if they aimed at the better regulation rather than the total suppression of the drink traffic.

May I quote from the synopsis of a report of the True Temperance Conference, which was sent to me when in London:

> It would conduce substantially to the spread of temperance, as well as to the general comfort and well-being of the community if the houses in which excisable beverages are sold were developed into real public refreshment houses, with due provision for the consumption of other beverages, besides those which are alcoholic; of food where the demand exists; of comfortable seating and other accommodation; of conveniences for writing letters, telephoning, etc.; and of entertainment, such as games and music adapted to the locality and the class of customers. The whole appearance and tone of the house should and by the intelligent and effective carrying out of these improvements would be changed for the better to such a degree as to bring about a complete transformation of the public house, making it of real social utility.

This would make the public house a real working man's club to which he could bring his wife and family, but the "extremist" will not hear of this or any other measure calculated, as he says, "to make the public house more attractive." There is no desire to minimize the evil effects of the abuse of alcohol; but if the only sound ethical rule is that the rightfulness of an act is to be determined by its total consequences, then when we know of the evils the attempts to enforce prohobition has brought about elsewhere, would it not be wise to hesitate before adopting it? Here one finds it difficult to understand the working of other people's minds, for among the strongest advocates of total prohibition we find professed followers of Him who willed to turn water into good wine wherewith to furnish forth the marriage table, and whose Apostle Paul counselled Timothy to "Dring no longer water but use a little wine for thy stomach's sake and thine often infirmities."

You will not see much of the practical side of your work before your sympathy and support will be enlisted for all reasonable measures for the control of venereal diseases. I have never forgotten the first midwifery case I attended in my student days, when a woman was delivered of a dead syphilitic child. Here again we meet with people holding peculiar views. There are some—and pure and virtuous women are not the only people to be found among them—who have no sympathy for these sufferers and would, to use a familiar expression, allow them to "stew in their own juice," maintaining that they are being justly punished for their sin. It is charitable to believe that they hold this opinion in entire ignorance of the frightful suffering entailed on innocent women and children; otherwise we could not understand them using these diseases as an illustration whereby they would seek "to justify the ways of God to man."

The question of birth control is a very old one; Malthus, an English clergyman, in 1798 pointed out that there was a constant and irremediable pressure of population on the means of subsistence. However this may be in the mass, few will find fault with a recent statement that: "A duty rests upon every man to refrain from bringing new beings into the world, unless he can make reasonable provision for their maintenance."

There is a warning by Lord Sydenham that unless restriction will be systematically practised by our inferior stock, the effects must be to accelerate the rate of decadence of our race. If our democracy is going to be a failure, it will be due to the increasing disproportion between the people who could make it a success, and the inferior types who have always been the dupes of the demagogue and the revolutionary. Does this view influence those who from time to time deplore the prevalence of flat life in Sydney, which seems to them to sound the death knell of the family? A critic of Malthus wrote:

> Malthus's "prudential check" rarely operates upon the lowest classes; the poorer they are, usually, the faster do they multiply; certainly the more reckless they are in reference to multiplication. It is the middle classes, those who form the energetic, reliable, improving element of population, those who wish to rise and do not choose to sink, those in a word, who constitute the true strength and wealth and dignity of nations—it is these who abstain from marriage or postpone it.

We are crying out for immigrants, but we only require them with grit and determination of character which come only from breeding from a sound stock. It is strange that in a country where so much attention is given to improving the breed of our various kinds of animals, so little thought is given to that of our own stock. On the contrary, we have the sentimentalist with his parrot cry of "The baby our best immigrant!" who apparently would have all and sundry propagate like rabbits while the State is to ladle out doles for the support of the progeny. It is so easy to be a good fellow at other people's expense. He is a fit companion for the professional politician with his poisonous bait of "the baby bonus" which may secure the object for which it is set though it kill the self respect of those who take it. But as the law is for rich and poor alike, all are equally entitled to receive it.

It is now recognized that many obscure nervous disorders, mental defects of all kinds, blindness and disfigurements are due to venereal disease. When we have learnt by judicious measures to lessen—it is too hopeful to speak of wholly preventing—its incidence, in checking the evils arising from the abuse of alcohol and the indiscriminate propagation of inferior types, the task of dealing with our mental defectives will be much easier for their numbers will be very much less. For a far abler discussion of this subject than I am capable of, I refer you to the paper of Dr. Morris Gamble, in THE MEDICAL JOURNAL OF AUSTRALIA of July 21, 1923.

In the course of your practice weigh well all your utterances. Patients are apt to brood unduly over some casual remark. Especially should you be careful in cases of heart trouble. A patient's peace of mind may be destroyed and his future usefulness impaired because of what a doctor says after examining his heart. A gloomy prognosis may be given; yet the patient may live for many years, though in constant but needless dread of sudden death.

Beware of the fallacy of premature generalization. Letters have often appeared advocating the merits of a particular drug or line of treatment in some illness simply because of apparent success in a few cases. Learn to distinguish between the *post hoc* and the *propter hoc*.

The layman, often "most ignorant of what he's most assured," is ready to teach us our business, as recently shown by the agitation for acquiring Spahlinger's so-called specific and the willingness to give us very confident views as to the causation of cancer.

Doctors do not as a rule display the keen anxiety to ask for consultation as lawyers do to seek counsel's opinion. This may be due to some early experience. A young doctor commencing practice and rather puzzled over a case has asked for a consultation. Later on he is told by some candid friend: "Oh! I hear you were attending Mr. A., but didn't know what was the matter and had to get in Dr. B. to tell you." This unkind and really untrue interpretation of his very proper conduct may not unreasonably make him continue "on his own" a little longer with the most serious case he has. When called in consultation do not allow any but the most urgent matter to cause you to be unpunctual. Consider another person's time as important as your own.

Do not be anxious to appear "up to date" by too great readiness in adopting the latest scientific methods. A wise old doctor once said: "Science is a first-rate piece of furniture for a man's upper chamber, if he has common sense on the ground floor. But if a man has not got plenty of good common sense, the more science he has, the worse for his patient."

You will rarely be justified in letting a man know that he is going to die. There are exceptional cases where this may be necessary or at any rate to warn the friends; but this knowledge will generally come to the patient as soon as it is good for him to know it.

Though it is not wise to take too seriously all that one reads in the lay press, no one who loves our profession and is jealous of its good name, can fail to have noticed statements in disparagement both of it and its members. There is nothing new in this. In 1848 Dr. Russell Reynolds, already referred to, gave as one of the causes influencing the respect in which the profession was held at that time and which he thought was operating then to its serious disadvantages:

> The mental character and calibre of many who are induced to enter the profession simply as a mode of "getting a living," but who have never inquired for themselves and whose friends have never inquired for them whether they had any real liking or aptitude for the work.

To what extent this may be true today I can express no opinion, but I think we can most of us subscribe to his further statement:

> And if with regard to the position of the profession in popular respect there is that which we have to lament and the more so because it is in great measure dependent upon certain conduct of the profession to which exception must be taken, there is still much in which we may gratefully and hopefully rejoice. There is certainly no other profession which enjoys more of the public confidence and esteem and which, in a vast number of instances so thoroughly deserves them both.

In the preface to his fine work: "The Great Operations of Surgery" published in 1821, just over one hundred years ago, Sir Charles Bell wrote:

> The public who are so ready to determine on the merits of our profession, and even the patients who are to suffer are surprisingly ignorant both of the surgeon's motives for what he does and the propriety of the methods he puts in practice. He is continually operating in secret on a matter of necessity; the most sensible give the decision up to him; so that he is answerable to his own conscience and to that alone. Nor is the public aware of the temptations which men of our profession withstand. Credit for great abilities, gratitude for services performed and high emoluments are ready to be bestowed for a little deception and that obliquity of conduct which does not amount to actual crime. This is precisely the situation in which a man requires a thorough devotion to the principles of honour and right conduct to preserve him from the commission of error. These are the considerations which should make it the interest of society to hold the profession in respect and which make it the duty of every member of it to keep it pure.

Before going on to speak as to how he may best maintain the honour and dignity of our profession, I would mention a few men from different parts of the Empire who have worthily played their part.

On first seeing this tablet placed here to commemorate two of your predecessors I was reminded that among those who once listened with me to the introductory lecture at University College Hospital, were two men whom I was privileged to hold as life-long friends. They also made the supreme sacrifice in the Great War. Sir Victor Horsley, in an obituary notice written by another fellow-student, Sir Frederick Mott, is described as one of the "greatest surgeons and scientists England has produced." Charles Stonham, a surgeon on the staff of the Westminster Hospital, had served with distinction in the South African War. These men perished in the plenitude of their powers and in the full flower of their manhood. Robert Aspinall and Arthur Jekyll were cut down in the springtime of their lives while their blossom was yet a-ripening. But who would say that they by their example of courage, self-sacrifice and patriotism have not done more in their brief span of life to show us "what a piece of work is man" than many a one whose praises have been sung in loftier strains than mine?

Lieutenant-Colonel John McCrae was said to have been the most talented man in the medical profession in Canada. He, too, fell a victim to the war and died of a virulent type of pneumonia at Wimereux in January, 1918, shortly after being appointed Medical Consultant to one of the English armies in France. He was at the second battle of Ypres when the Canadians stopped the gap left by the Senegalese who had given way before the awful gas. Those doctors who were on the staff of the Australian Hospital at Wimereux at that time and saw the distressing condition of the gallant Canadians who were brought there, will readily share his righteous indignation and understand his call to

> Take up the quarrel with the foe

which appears in the beautiful lines he wrote entitled "In Flanders' Fields." I propose to take his concluding lines and adapt them as an appeal to us from these noble dead to maintain a high standard of professional conduct.

> To you from falling hands we throw
> The torch;—be yours to hold it high.
> If ye break faith with us who die
> We shall not sleep, though poppies grow
> In Flanders' Fields.

We hear a great deal about the progressive times in which we are living. Certainly there is much to elicit our admiration in the wonderful achievements of science, but there are those who think that in the domain of conduct we have nothing to congratulate ourselves upon; and it is not easy to refute them. It is also said to be a materialistic age and the acquisition of wealth the universal aim. From what is occurring here it would seem that the struggle to "get money, honestly if you can, but get it," is as rife today as it was in the age when Horace deplored it.

Money is not altogether to be despised. The old doctor already referred to once said: "A man's learning dies with him; even his virtues fade out of remembrance; but the dividends on the stocks he bequeaths to his children live and keep his memory green."

However, it would seem that the desire for gain underlies many of the actions by which men have forfeited the respect of their fellows. There is an old saying that: "Medicine is a noble profession, but a vile trade." It seems quite correct from what we can see in the course of our tram journeys for a firm to extol the healthy and beautifying properties of their particular brand of soap, but a doctor cannot advertise his qualifications and curative powers in this way. There are, however, other but less open methods of obtaining practice. In the early days of your school late editions of medical or surgical works were sent to graduates just commencing practice in the country, but now, whether or not as a result of the progress we are making, it seems that this has developed into a practice of sending at Christmas time presents of silk stockings to suburban midwives. There may be no harm in these doings which seem kindly enough acts, but they are apt to be looked upon as simply "touting for practice," so it is as well to avoid even the appearance of evil.

Your sympathy more than your pocket will perhaps be appealed to early in your practice, and till your character is known, to perform acts of an unprofessional and even criminal nature. Kindly but firmly reject these appeals lest by an easy descent you drift into the ranks of the abortionists.

You will often be asked for certificates of various kinds and there is a great deal of laxity in the way these are given. According to statements made in the Arbitration Court certain employees have reduced malingering to an art. It was said that it was not uncommon for a doctor to hand a certificate to a man leaving a blank open space in the certificate for the worker to fill in the time. A case was cited where a man got a certificate and fought in the prize ring that very day. A man once asked for a certificate to enable him to avoid

serving on a jury because he wished to attend a sports meeting on that day. He was quite taken aback when his request was refused and said he thought any doctor would do it!

You will often be asked to certify as to some real or pretended injury whereby it is hoped to exact compensation from the Government or some rich firm or employer. Do not let your sympathy or desire to stand well with some patient allow you to state more than you honestly believe. The lesions of secondary syphilis have been attributed—it is difficult to believe that it was due to ignorance—to injuries received owing to the carelessness of a tram guard in starting a tram before the patient had alighted. Remember there is always another party to be considered. Above all, do not listen to the promptings of any solicitor taking up what we may call a "speculative action" where you may be promised a fee in proportion to the amount of damages obtained. The profession rarely appears to less advantage than in those cases where doctors appear to be "taking sides." It is not every man who can bear to have

> All his faults observed
> Set in a notebook, learn'd and conn'd by rote,
> To cast unto his teeth.

And doctors as well as others may be subjected to a bad quarter of an hour at the hands of counsel who, like a cock on his own dung-heap, delights in raking up buried and unsavoury matter. Surely the cause of justice and the reputation of the profession would be better served if the matter in dispute were settled by a conference between the doctors representing each side and one appointed by the Court.

In these days of anæsthetics and antiseptics many more men are capable of operating satisfactorily than was formerly the case, where great rapidity and dexterity and nerve were required in the surgeon. Sir Charles Bell wrote:

> In truth the anxiety of a surgeon before an important operation is the greatest any man can suffer, where there is not a consciousness of crime; and do not suppose that this belongs to a surgeon in his early practice only or to such feeble spirits as cannot summon resolution to do their duty. The greatest surgeon this country has produced, the celebrated Chesselden, was even in his later days anxious to sickness before the performance of a severe operation.

One of the most anxious situations you will have to face is that when the question of an operation arises. I think there is no better way of helping you to come to a decision than to imagine some one very dear to you, in the position of the patient. A consultation is often advisable. Suppose an operation is decided upon, who is to perform it? It is the patient's undoubted right to choose the surgeon if he so desires. If the matter is left in your hands, you must ask yourself if you are capable of carrying it out successfully. This is a most important matter, for it may concern not only the life but the future usefulness of a fellow creature and perhaps the whole prospects of a family. In this respect the medical profession stands alone, dealing as it does with the great issues of life and death. There is on the one hand the prestige to be gained by a successful operation perhaps on a well-known person, not to mention a handsome fee and the grateful thanks of the patient if all goes well. But what must be the feelings of a man induced by these considerations to undertake an operation he was unfitted to perform and which has resulted disastrously for the patient? If you are not sure of your powers, I beg you with all earnestness to call in some colleague even though he be not older in practice, so long as he is abler than yourself to deal with the particular case in hand. You will be amply rewarded by the approval of your own conscience. Cultivate your sense of responsibility and learn to recognize your own limitations.

I once heard it said of a practitioner and evidently as being in his favour that "he would tackle anything." I could only hope that his sense of responsibility was not fullly satisfied by the knowledge that he was legally entitled to sign death certificates.

Cases of urgency of course occur, especially in the country where there is no alternative and the doctor must take the responsibility on himself and do the best he can. On the other hand there are many patients needing operative treatment about which there is no urgency; they could easily be transferred to competent hands; but there is ample evidence to show that many such patients are in fact operated on with very unsatisfactory results which have to be rectified by more expert surgeons.

There may be some here who think I have made too much of some trifling irregularities which, even if they exist, are not worth worrying about in this imperfect world and really do no great harm. Should there be any such, with them I would plead like Hamlet with his mother:

> . . . For love of grace
> Lay not that flattering unction to your soul,
> That not your trespass but my madness speaks:
> It will but skin and film the ulcerous place;
> Whiles rank corruption, mining all within,
> Infects unseen.

In most things if you aim at superiority you will be sure to rise above mediocrity; if you are content to aim only at mediocrity, rest assured you will fall below it.

I have borrowed much in this attempt to point out some of the rocks and treacherous shoals on which persons of our calling have made shipwreck of their lives, as well as some of the warning beacons which may serve to guide you safely through the yet uncharted waters of your professional careers. I would have you worthy to rank with these great ones of our profession so that you, in your turn, will "hold high the torch" whose light, though it has sometimes failed, has brightened many of the darkest hours in the lives of men and that you will "carry on" in such a way that our fallen *confrères,* whether or no they lie in Flanders Fields shall with our poet Kendall here in Australia:

> Surely take their fill
> Of deep and liquid rest forgetful of all ill.

Before I close I would respectfully refer to the loss the State has sustained in the death of His Excellency the Governor, the late Sir Walter David-

son, who was laid to rest yesterday. Others have spoken of his great work for the Empire. We can never be sufficiently grateful for the splendid example he set us in his determination to do what he considered his duty, duty often performed at the cost of personal suffering. That his heart was in our hospital work was shown by his regular attendance at the annual meetings. Our respectful sympathy goes out to his children and the gracious lady who so bravely and untiringly shared his labours and who has won the admiration and respect of the whole community.

And now, in conclusion, as this is probably the last occasion on which I shall have the privilege of addressing either present or prospective members of the profession to which I have the honour to belong, I hope that in what I have said I have given offence to none. I have gathered that the times call for some plain speaking. I have uttered many commonplaces; but there is much wisdom in commonplaces which we should all be much the better for weaving into the web of our daily lives. You have chosen a noble profession and it is for you to see that you do all in your power to enhance and nothing to lower its reputation. You may not meet with any great rewards or any public recognition of your services nor may you attain that object of a pitiful ambition, a "crowded memorial service," but you can so do the work to which you have set your hand, that when, in its appointed time to each of you "the summons comes to join"

> Th' innumerable caravan that moves
> To that mysterious realm where each shall take
> His chamber in the silent halls of death,
> You go not like the galley slave at night,
> Scourged to his dungeon; but approach the grave
> Like one who wraps the drapery of his couch
> Around him, and lies down to pleasant dreams.

Reports of Cases.

A CASE OF "PINK DISEASE."

By E. S. LITTLEJOHN, B.A. (Sydney), M.D., Ch.M. (Edinburgh),
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The following is a perfectly typical case of mild "pink disease" [synonyms, erythrœdema (Swift), acrodynia (Byfield, Weston, Vipond), dermato-polyneuritis (Thursfield and Paterson)] and is worth recording because the patient was six years and three months of age, a year older than any patient with this disease whose illness has been recorded, as far as I am aware.

The disease occurs in the great majority of cases in children under two years, the youngest so far being a child of three and a half months, reported by Wood.[1]

Hitherto the record of only one child over the age of four years has been published by Weston;[2] this patient was five years of age.

G.L., *ætatis* six years and three months, was sent to the Royal Alexandra Hospital for Children on September 13, 1923, by Dr. Clubbe, with the following history. He had had ringworm of the scalp for the previous five months. He had been wasting rapidly for the previous month. He had cold sweats, no appetite, would not play, but lay about all day. The child was evidently very weak, "climbed up himself" when getting up from the floor and said that he had pains in the legs.

The boy's mother informed me that he had always been a perfectly healthy active boy until five months previously, when he had developed ringworm of the scalp. After this had been cured, he had an attack of "hives" lasting a few days and had then been quite well until about one month previously, when he had become fretful and irritable, had entirely lost his appetite, had sweated a great deal and had rapidly wasted and got very weak. He had also been very sleepless and restless at night and for about three weeks had an irritable rash over his trunk and limbs; he had complained of pains in his hands and legs. He had had no cold in the head, running at the nose, sore throat or mouth and no cough.

On examination the boy was found to be irritable and distressed. When placed in a sitting position he held his head down, frowning and whimpering and looking very miserable, but photophobia was not at all marked. He was sweating profusely all over his trunk and limbs which exhibited an extensive miliarial rash, with many vesicles and much desquamation. He was much wasted and had a considerable degree of muscular weakness, sitting up and standing only with much effort and unsteadiness. His hands and feet were quite cold. There was no definite paralysis and no rigidity.

The knee jerks were absent, but sensation to pin pricks in the legs was quite normal.

There were a few enlarged glands in the axillary, inguinal and femoral regions, the glands being smooth, freely movable and not at all tender.

Kernig's, Babinski's and Brudzinski's signs were all absent. There were no signs of catarrh in his air passages and he had no stomatitis or gingivitis.

There was no pinkness or redness of his hands, feet, nose, cheeks or ears at this stage.

During the next few days he continued to be irritable and sleepless and had no appetite. He either lay curled up in bed or sat up with his head bent between his knees in the characteristic attitude. He continued to sweat profusely and the miliarial rash remained. His hands and feet were always cold. On September 17 it was noticed that his ears were pinkish-red and his palms and soles and the palmar and plantar aspects of his fingers and toes exhibited the typical peculiar pink coloration characteristic of "pink disease."

His temperature varied between 36.1° C. and 37.8° C., being generally normal or subnormal with occasional slight rises. No reaction was obtained to the von Pirquet and Wassermann tests. A lumbar puncture was performed and the cerebro-spinal fluid was found to be clear, not under increased pressure, with no abnormal cell content and sterile on culture. A blood count revealed a leucocytosis of 15,000 cells per cubic millimetre. The urine contained no albumin, pus nor sugar and was sterile on culture. The bowels were inclined to be constipated. An attempt to aspirate some fluid from one of the enlarged inguinal glands for cultural purposes was unsuccessful.

On September 24 he was distinctly better, was much less irritable and was eating and sleeping better; the sweating had almost ceased and the miliarial rash was clearing up. His muscular power was much improved and the pinkness of his hands and feet and ears was slightly less.

He continued to improve from then onwards and by October 12 was happy and smiling and practically well, the pinkness having disappeared, the knee jerks being normal and the enlarged lymphatic glands having returned practically to normal size.

The skin was seen to be peeling off his hands and feet in large flakes. The duration of the illness was thus about two months.

References.

[1] A. Jeffreys Wood: "Erythrœdema," THE MEDICAL JOURNAL OF AUSTRALIA, February 19, 1921, page 145.
[2] W. Weston: "Acrodynia," *Archives of Pediatrics*, September, 1920, page 358.

Reviews.

DENTAL SURGERY AND PATHOLOGY.

In the fifth edition of "Dental Surgery and Pathology" Sir J. F. Colyer has excluded some sections of the earlier work, *exempli gratia* the description of the technical details involved in the insertion of fillings and the chapter upon bacteriology, so that he might devote more space to other subjects of paramount importance.[1]

The author has called to his assistance in some sections of the work other well-known writers. Mr. Harold Chapman is a contributor of a section on "Fixed Appliances for Regulating Teeth." Some two hundred pages are devoted to the pathology and treatment of irregularities in the position of the teeth and this section should prove of great interest to both the specialist in orthodontia and the dental practitioner. Mr. Steadman's chapter on "Local Anæsthesia in Dental Surgery" is very useful and should greatly assist those who desire to become expert in the field of "block anæsthesia." Dr. Howard Mummery has collaborated in the chapter on "Caries of the Teeth." This is a valuable section, notably where the subject of susceptibility and immunity to caries is discussed; the presentation of abundant clinical evidence shows the close relationship between the use of sugar and the amount of caries.

Of particular interest to the dental practitioner is the chapter upon chronic general periodontitis and here are set forth in a clear manner treatment appropriate to the varying types of this widespread disease and the conditions under which general extraction should be adopted. Incidentally it is satisfactory to note that treatment of this disease by means of ionic medication as practised by Mr. Norman G. Bennett and others is commended.

A special chapter is devoted to the saliva and extended notice is given to the research work upon the secretion of saliva carried out by Professor H. P. Pickerill.

In another section of the book thirty pages are devoted to a consideration of the diseases arising from sepsis in connexion with the teeth. This should be read and re-read by all those dental practitioners who desire to discharge more fully their responsibilities to their patients in the avoidance of all forms of dental sepsis.

The chapter on extraction of the teeth and post-operative treatment contain good sound advice, but there are very many difficult extractions that can be undertaken with more assurance of ultimate success, when use is made of surgical burrs in the engine, to remove the alveolar plates.

The last chapter entitled "Radiographic Changes in Chronic Infection of the Jaws" is contributed by the author's brother, Dr. Stanley Colyer, and is of particular assistance to the dentist who is carrying out radiographic examinations in connexion with his daily practice. It gives in the text and by the numerous beautifully reproduced radiograms the salient points in interpretations of the radiographic shadows in dental films.

The subject matter throughout is clearly presented and there is a wealth of well selected illustrations and diagrams which complement the text.

Altogether this is an excellent text-book and confirms the high opinion formed of the author's work in the earlier editions of the book.

CLINICAL EXAMINATIONS AND SURGICAL DIAGNOSIS.

THERE is a French precept of medicine: "*Il n'y a pas de flair diagnostic; il n'y a que de la méthode*" and Mr. Lejars seems to have made this the basic principle of his new book on clinical examination and surgical diagnosis.[2] The practical value of his earlier publication on urgent surgery will be remembered and there is much of the same atmosphere in the present work. In the former publication the atmosphere was that of the operating theatre, in the present production it is that of the ward.

For M. Lejars is not interested in mere academic discussion. He seeks to find an answer to the question: "Of what must one think in this particular region?" And not only does he supply the answer out of the vast storehouse of his own experience, but he further demonstrates the manner in which the diagnostician should approach his subject in order to arrive at a correct solution of the problem.

Thus, the book has a point of view which is purely objective. The instruments of precision so dear to the modern, if not disdained, are certainly not employed. There is no apparatus; he unravels his tangled skein with the eye and the hand alone. Such a book has inevitably the fault of its kind. The unity of disease is disregarded; we get detached scenes rather than the complete play. Lesions are shown limited to areas as if there were anatomical barriers to the malady. The lesion is so magnified that the rest of the patient remains out of focus.

The illustrations which number nine hundred and seven and are excellent photographs of the original, are also responsible for the impression that the book is an atlas of regional disease. In passing there are noticed a number of illustrations of "*les gros ventres*," showing that the author does not hesitate to poach on the pelvic preserves of the gynæcologist. Too often an equal prominence is given to common and uncommon lesions. The result may be that the student's sense of proportion will be disturbed, just as he may lose his appreciation of the subjective side of the problem.

For the rest, the book which is well printed and copiously illustrated, has been written in the breezy, colloquial style characteristic of "Urgent Surgery." The author's personality breathes into every page and it is not difficult for the reader to imagine himself listening and observing at the clinic of the Hôpital Saint Antoine. "Exploration Clinique" will be found among those books of the practising surgeon to which he resorts the more readily, since they represent the harvest of an experienced surgeon. It needs, however, the association of a complementary treatise on surgical pathology to make good its defects and to enhance its value.

THE CLINICAL EXAMINATION OF THE NERVOUS SYSTEM.

SOME writers of text-books on diseases of the nervous system appear to regard it as a duty to their readers to open with a chapter of methods of clinical examination. This chapter, often covering many valuable pages, is out of place and invariably skipped. Its proper place is in a separate manual and its proper writer a practised clinical tutor. Such a manual we have before us from the pen of Dr. Monrad-Krohn, of Christiania.[1] Proof of the utility and appreciation of the manual is shown by the brief period which has elapsed since the publication of the first edition (see THE MEDICAL JOURNAL OF AUSTRALIA, August 18, 1923). The main feature leading to success is that description is confined, as far as possible, to methods of examination alone. For example, the knee jerk and how it is elicited—all we want to know—is disposed of in a dozen lines, physiological and diagnostic details are rightly omitted. Another gratifying feature is that the author recognizes the importance of examining a patient from the psychical as well as the physical side and accordingly includes a narration of methods of determining mental states. The new edition is somewhat enlarged by inclusions which the advance of neurology demands and we again recommend the work.

[1] "Dental Surgery and Pathology," by J. F. Colyer, K.B.E., F.R.C.S., L.D.S.; Fifth Edition; 1923. London: Longmans, Green and Company; Demy 8vo., pp. xiv. + 931, with six plates containing 30 radiograms and 951 illustrations in the text. Price: 32s. net.

[2] "Exploration Clinique et Diagnostic Chirurgical," par Félix Lejars; 1923. Paris: Masson et Cie; Royal 8vo., pp. 782, with 907 illustrations in the text. Price, net: Frs. 50 stitched; 60 bound.

[1] "The Clinical Examination of the Nervous System," by G. H. Monrad-Krohn, M.D. (Christiania), M.R.C.P. (Lond.), M.R.C.S. (Eng.); with a Foreword by T. Grainger Stewart, M.D., F.R.C.P.; Second Edition; 1923. London: H. K. Lewis and Company, Limited; Crown 8vo., pp. xvi. + 148, with 33 illustrations, including four plates. Price: 6s. net.

The Medical Journal of Australia

SATURDAY, JANUARY 5, 1924.

A Retrospect.

THE year 1923 is dead and gone and a new year has been born with all the customary hopes and promises, anticipations and forebodings. The experiences of each year are used by the wise as guides for future actions and activities; successes and failures alike deserve notice. The year that is past, need not be emblazoned as one of great events or startling progress, but it has been characterized by a slight speeding up, an increase of the high pressure of recent times, with its attendant bustle and hurry. There is some danger attaching to this fast movement, at all events in the world of science. In the striving to reach a goal quickly, whether the objective be wealth, fame or the accession of knowledge, false hopes may be aroused and premature claims may be made. The medical profession, the guardian of the health of the people, has need for caution, thoroughness and deliberation. The temporary or even permanent advantage of the individual is of no moment; all that matters is a steady progress toward a clear understanding of the real problems of health and disease.

The Medical Profession in the Commonwealth.

The increase in the numerical strength of the medical profession in the several States has been maintained at a slightly higher level than in previous years. It is estimated than the increase in the population of Australia during the twelve months ended September 30, 1923, was 2.08%. The number of graduates in medicine newly admitted at our own Universities was greater in 1922, while fewer practitioners have come from Great Britain and elsewhere. As a result the medical profession has increased numerically by about 8%.

British Medical Association.

Last year reference was made to the model Memorandum and Articles of Association for the use of Branches seeking incorporation under the *Companies Acts* as companies registered not for profit. The Federal Committee of the British Medical Association in Australia has completed this document and has submitted it to London for the approval of the Council of the Association. Branches seeking the advantages of incorporation will now approach the Council for specific sanction and will be able to take the necessary steps in their respective States to obtain registration. The powers and privileges of an incorporated Branch will be identical with those of the parent Association. It is recognized that this expedient will draw the Branches more closely to the organization in Great Britain and will enhance at the same time the value of these integral parts of the Association to the profession and to the community. Notwithstanding the oft-repeated gibe that the British Medical Association is one of the most powerful of the trade unions, the constitution of the Association deliberately and specifically forbids it to attain any of its objects in a manner or by means that would bring it under the definition of a trade union. It cannot exercise compulsion on its members in connexion with a dispute with employers; it has no power to levy funds; it cannot organize a strike; and it cannot employ its funds to compensate its members for pecuniary loss arising from obedience to a command of its executive to refuse to render service to any given employers. On the other hand the constitution provides means for the mutual protection of medical practitioners and for the maintenance of the honour and dignity of the profession. The Branches in Australia will be better equipped in this respect when clothed with all powers and responsibilities than at present when they, with two exceptions, have merely the restricted rights of Branch-Divisions.

The Federal Committee has continued to carry out its functions to the benefit of the medical profession in the Commonwealth. Its activities during the year 1923 have been characterized by an evident recognition of the paramount importance of preventive medicine. For a considerable time the Committee has conferred in an informal manner with the Director-General of Health on divers matters affecting the health of the people. These

conversations have been productive of good. As a result there has arisen a closer and more sympathetic liaison between the practising portion of the medical profession and those members who are specifically engaged in the administration of the health laws. A sub-committee of the Federal Committee is now engaged in drafting a report on a practical scheme for the control of infective diseases by coordinating the activities of the general practitioner and the departmental medical officer. For the present the Committee is not prepared to attack the problem of the relation of the Federal authority to the State authorities in this regard. On the other hand it is recognized that a policy of uniform measures of control and uniform system of collaboration is needed in order that the same benefit may be derived in all parts of the Commonwealth.

The Federal Committee has instituted a gold medal for distinguished service and has awarded this prize for the first time to Dr. W. T. Hayward, C.M.G., and to Dr. R. H. Todd. The yeoman service that both have rendered to the British Medical Association is fittingly recognized in this way.

At the special meeting of the Federal Committee held in Melbourne during the Congress week, preliminary steps were taken to formulate a uniform policy of the medical profession in Australia in connexion with national health insurance. In view of the appointment of a Royal Commission by the Federal Parliament to examine and report on this matter, the Committee resolved to collect information concerning the working of the *National Health Insurance Act* of Great Britain, especially from the point of view of medical benefit and to elicit the opinions of those practitioners who may have had some experience of this form of contract practice. The Branches would have to advise the Committee firstly whether or not any considerable section of the community is at present unprovided with medical attendance; secondly, if such a section of the community exists, whether it would be reached by any scheme of national health insurance; thirdly, whether or not the medical profession could serve the community better under a scheme of medical benefit in connexion with national health insurance than under the existing arrangements with the friendly society lodges, hospitals, eleemosynary institutions and charitable aid or under any other plan; fourthly, under what terms and conditions the medical profession would agree to work under a national insurance scheme and lastly, what steps should be taken to influence public opinion in regard to the professional aspect of this matter. The members of the Royal Commission have already revealed that they lack an understanding of the elementary principles underlying the movement. The evidence sought and taken is largely irrelevant and seems to be taking the Commission far outside the limits imposed by its reference. In these circumstances the members of the Branches are strongly urged to study the reports published in *The British Medical Journal* and its supplements in October, 1923. At the outset the medical profession must make it abundantly clear to the public that in the matter of giving medical attendance to the wage earner and to the man of small means political considerations have no place and that the best service is that which brings the doctor and his patient in close relations without any third party intervention. The most important thing in contract practice is the maintenance of friendly relations between the doctor and his patient. The members of the Royal Commission seem to be unaware of the very large amount of gratuitous service rendered by the medical profession. No one who needs a doctor, ever appeals in vain.

The Australasian Medical Congress (British Medical Association).

The year 1923 will be remembered as the date of the first session of the Australasian Medical Congress (British Medical Association). The medical profession in Melbourne had risen to the occasion and had organized a congress of unusual merit. The success attained both from a scientific and from a social point of view has been recognized by all. Last year we anticipated that under the management of a powerful executive committee with Mr. G. A. Syme as President and Dr. A. L. Kenny as Honorary General Secretary, the unqualified success of the first Congress under the Federal Committee would be assured. Our anticipations have been realized. The Executive Committee, having performed its work so worthily, is now seeking to place a crown on its undertaking by establishing a

record in regard to the publication of the Transactions. Arrangements have been made for the publication of the Transactions in a series of supplements to THE MEDICAL JOURNAL OF AUSTRALIA. The first supplement will appear on January 19, 1924; the last will appear on April 12, 1924, that is five months after the end of the session. This method of publishing the Transactions has the double advantage of expedition and of wide circulation. The series of thirteen supplements can be bound separately.

Medico-Politics.

The most important matter in the realm of medico-politics in Australia that has engaged the attention of governments and of the medical profession, is the hospital question. *The Hospitals and Charities Act* of Victoria has been placed on the statute book. The measure as originally drafted was amended in various directions in the course of its passage through Parliament. The clauses dealing with what is known as intermediate hospitals were withdrawn and a special measure to govern these institutions was foreshadowed. Subsequently there has been some negotiation between the Government and the Council of the Victorian Branch of the British Medical Association on the provisions of this new measure. The Council of the Branch has called attention in its annual report to the necessity of safeguarding the interests both of the patients and of the nurse proprietors of private hospitals. It would seem that the expedient introduced some time ago in Victoria of inducing the managers of private hospitals to set aside a number of beds for persons whose means are insufficient to enable them to pay the usual fees, may render the establishment of large intermediate hospitals unnecessary, at all events for the present. In New South Wales and in other States the problem of the public hospital has still to be solved. The time may be not far distant when the medical profession will reconsider its attitude to this question. Honorary service in public hospitals should be maintained, but this is only possible if the hospitals remain charitable institutions for those who cannot afford adequate treatment elsewhere. So far no progress has been made toward the introduction of a system similar to that known in the United States of America as hospital standardization.

Preventive Medicine.

In 1917 the Commonwealth Government and later the various Governments of the States entered into an agreement with the International Health Board of the Rockefeller Foundation whereby the generous offer of the latter organization to provide experts and certain large sums of money to carry out survey work in connexion with hookworm disease was accepted. Not only was the Australian Hookworm Campaign instituted, but subsequently the Commonwealth Government accepted a further offer of collaboration in connexion with departments of industrial hygiene, sanitary hygiene and tropical hyiene. The arrangements were for varying periods and these periods have now expired. Within a few weeks our American colleagues whose skilled and able work has proved of such great value to Australia, will say good-by. Exception has been taken by some persons to the fact that we have permitted a foreign organization to provide men and money to carry out work that should have been undertaken by Australians and with Australian money. It should be pointed out that Mr. John D. Rockefeller has specifically maintained that he amassed his millions not only in America, but in every country in the world. In seeking the best use for his immense wealth he insisted on the principle that humanity as a whole, and not merely the nation, should benefit; that the International Health Board should be regarded as a truly international organization, not American. In the next place the invitation that has been addressed to all countries, is of a very carefully conceived kind. The accepting Government has to undertake to bear a proportion of the cost of the campaign. It has to guarantee that the work begun with the collaboration of the trained workers of the International Health Board will be continued after the period of initiation without this aid. Lastly we would urge that Great Britain as well as all other countries in the world have had no scruples in accepting the aid of this wonderful institution in furthering the health interests of the community. The Australian Hookworm Campaign has completed its five years of initiation and the Commonwealth Department of

Health will continue the work without foreign aid. Similarly the Health Department will develope its branch of industrial hygiene with Dr. D. G. Robertson and Dr. F. L. Kerr as its Australian experts. Dr. R. W. Cilento will continue the work of tropical hygiene and the sanitary engineering work so ably started by Colonel F. F. Longley will not languish on his departure. Australia is under a debt of gratitude to the International Health Board and to the able workers of the Board and will manifest that gratitude by maintaining the standard of the work under its permanent organization.

Part of the programme of the Commonwealth Health Department has been devoted to the establishment of a chain of laboratories in country towns for the assistance of the practising part of the profession. The establishment of the laboratory at Bendigo has been watched with great interest, since this may be regarded as a crucial experiment. With one accord the practitioners in Bendigo have found the laboratory of immense value. It has provided facilities previously unattainable for the application of bacteriological and biological tests and investigations in connexion with the diagnosis of disease. It has been the means of instituting research of a valuable kind into the prevalence of diphtheria, the incidence of susceptibility to that disease and the value of immunization. The laboratory has been found to be of practical value to individual practitioners, not only as a place where examinations can be carried out, but also as a place where the practitioner can himself undertake investigations in his spare time. The laboratory at Rabaul has also justified its existence under the able direction of Dr. G. M. Heydon. Other laboratories are about to be opened and these, too, will without doubt be welcomed by the local members of the medical profession. At present the supply of trained bacteriologists does not seem to suffice for a rapid extension of this scheme, but the resources of the medical profession in Australia are considerable and he would be a bold man who would predict a failure because of a lack of competent men or women to carry out the work.

The industrialist is now realizing that it pays to look after the health and comfort of his employees. Steady progress has been made in the year that has just terminated in inducing the employer and the worker to have faith in the "industrial physician" as he is called in the United States of America. The former is learning that it is preferable to have contented, efficient men and women each working at a task suited to his or her temperament and physical qualities than to be compelled to goad half exhausted workers to complete their tasks. Under modern conditions the medical officer of an industrial establishment first of all endeavours to eliminate all noxious elements from the workshop; then he introduces general hygienic principles to raise the common standard of health of the workers; next he seeks to fit the work to the worker and lastly he insists on the adoption of humane treatment of all persons engaged in the industry. The result of this regulation of the workshop is the improvement of the health of the individual, the fostering of a spirit of contentment and the awakening of an inclination to work. The happy and healthy worker produces more with a smaller expenditure of energy than does the discontented and neglected artisan. During the year the workers have begun to recognize that there is no need to suspect the medical officer of being in conspiracy with the employer to extract the last ounce of energy from the worker.

The Problems of the Pacific.

In August the second Pan-Pacific Science Congress was held in Melbourne and Sydney. The discussions were of unusual value, chiefly because the majority of the speakers recorded their own experience and expressed views based on their own original work. In the course of these discussions the subject of the problems of the Pacific Oceon in regard to its medical and hygienic aspects became a burning one. The members expressed the opinion in the form of a resolution that the preservation of the health and life of the native races of the Pacific was the matter of the greatest urgency. There are indications that the countries concerned in this part of the world will collaborate in the institution of a Pacific medical service. The proposal has been made that the International Health Board of the Rockefeller Foundation, as a

neutral organization, should act as the liaison officer to coordinate the different interests. It is too early to anticipate the details of the scheme, but it should be noted that the first step has been taken.

Drugs and Foods.

The Commonwealth and State authorities have again considered the question of the regulations under the *Pure Food Acts* in reference to infant foods. For a considerable time this journal has called attention to the untenable position adopted by the authorities in setting up an artificial standard for these foods. Nature in her wisdom permits a very wide physiological variation in the composition of the milk of human beings and of the lower animals. It is neither in accord with the laws of physiology nor sound in logic to regard the average composition of human milk as an inflexible standard for all foods for infants. The authority demands that all food preparations intended for infants must be labelled as unsuited for infants under six months of age unless the protein, fat and carbohydrate contents coincided with the arbitrary standard. A concession has been made in that a variation of 35% above or below the standard is permitted. Quite recently this matter has again been discussed and some further concessions have been made. There is no need for the complicated unreasonable regulations. The manufacturers should be required to publish on the label the actual composition of the food. Experience soon reveals whether the special foods are or are not suitable as food for infants. No artificial food can compare with mother's milk, but there are times and circumstances when mother's milk is not available or cannot be given for other reasons. The authorities should not attempt to dictate which foods may be used as substitutes. All that they should do is to see that the preparations are true to label.

In another respect the customs authorities have erred very grievously. Certain biological products and other proprietary preparations are prescribed for particular diseases and in some cases these remedies are specific. Every physician is aware that he obtains better results with one brand of serum or glandular extract than with another. To impose a heavy import duty on valuable medicaments and biological products is wrong, because this means that the unfortunate sufferer from an infection or other disease will have to pay an unduly high price when the brand chosen is one imported from outside Australia. The collection of import duty on "Insulin" which under the most favourable circumstances is very expensive, is an illegitimate method of increasing the national revenue. Many physicians hold that the product manufactured locally at the Commonwealth Serum Laboratories is not as good as that imported from England. It may be that this claim is a prejudiced one, but each physician must be at liberty to form his own judgement and is in duty bound to prescribe the medicament which he believes to be the best. There is no justification to create a monopoly for the Commonwealth Serum Laboratories, nor is it necessary, for its products are known to be excellent. The Laboratories must compete on equal terms with other commercial firms. There is a demand that these import duties should be removed.

The Medical Journal of Australia.

A year ago we announced that the Directors of the Australasian Medical Publishing Company, Limited, were considering a scheme for the extension of the printing arrangements to enable this journal to be increased in size and to allow the Company to undertake other scientific printing. Some delay has taken place, but the Directors are now turning to the members of the several Branches of the British Medical Association for financial aid in carrying out this project. It is proposed to issue debentures of £25 each, bearing interest at the rate of 10%. Any member who desires to invest money in this undertaking, should get in touch with one of the three members of the Australasian Medical Publishing Company, Limited, representing the Branch to which he belongs, or should communicate with the Secretary of the Company, Dr. R. H. Todd. It is proposed to erect special premises and to instal the plant at the earliest moment, so that further delay may be obviated.

THE MEDICAL JOURNAL OF AUSTRALIA extends hearty wishes for a prosperous New Year to all its readers.

Abstracts from Current Medical Literature.

THERAPEUTICS.

Treatment of Syphilis.

J. A. FORDYCE (*Journal of the Indiana State Medical Association*, July 15, 1923) gives a summary of the treatment of syphilis employed in the dermatological department at the College of Physicians and Surgeons, New York City. Abortive treatment, given before the occurrence of a reaction to the Wassermann test consists of eight intravenous injections of "Arsphenamine" in doses of 0.3 to 0.5 gramme. The first three injections are given every other day, the remaining five every five to seven days. A second course of six injections is given after intervals of four to six weeks. Monthly blood tests should be made for twelve months and if a power to react to the Wassermann test developes in the serum the patients should be treated as for secondary syphilis. Secondary syphilis is treated by one or two injections of mercury to prevent a Herxheimer reaction. These are followed by eight doses of "Arsphenamine" as described above. Intramuscular injections of 0.06 to 0.09 gramme of salicylate or 0.06 gramme of "Bichloridol" are given every four to seven days concurrently with the arsenic injections. At the end of four to six weeks the treatment is repeated, longer intervals (seven days) being allowed between injections. Four weeks later the blood is tested and if a reaction is obtained, a third similar course of treatment is given. If the serum fails to react, a rest of three months is advised followed by six arsenical and ten mercurial injections. Patients with involvement of the central nervous system require longer treatment and when the spinal fluid retains the power to react to the Wassermann test intraspinal injections should be given. Tertiary and latent syphilis is treated in the same manner as secondary syphilis, but less intensively and iodides are used freely during the rest periods. The total amount of treatment necessary is very much greater than in secondary syphilis. Great care should be exercised in treating pregnant women. Two courses of six doses of "Neo-Arsphenamine" and ten doses of mercury injections are given during pregnancy. Congenital syphilis is treated by intramuscular injections of "Neo-Arsphenamine" and mercuric chloride given separately. At least two full courses are given. In all instances a cathartic should be taken before treatment, abstinence from food should be observed before and after injections and rest after injections. Lumbar puncture should be performed to determine cerebro-spinal involvement or otherwise. A patient is not cured until the serum has failed to react to the Wassermann test for at least two years. A patient is not cured as long as reactions are obtained in the cerebro-spinal fluid. Contraindications to "Arsphenamine" treatment are organic disease of heart, kidneys or other viscera, blood vessels or aorta; extreme malnutrition and cachexia due to other diseases; severe nitritoid or cutaneous reactions following arsenical treatment; arsenical neuritis and jaundice the result of arsenical intoxication.

Mercury in Lethargic Encephalitis.

ERNST BILLIGHEIMER (*Klinische Wochenschrift*, June 25, 1923) has employed mercury in the treatment of lethargic encephalitis. As much as 5.0 grammes daily was administered in the form of mercurial inunctions, though less frequently injections of mercury salicylate were used. The author states that in the acute and sub-acute stages of the disease the results were immediate and striking. The patients rapidly became free of symptoms and signs and progressed to recovery. In chronic forms of the disease, on the other hand, the results were indeterminate or disappointing. In only two patients suffering from the disease in a chronic form could mercury be said to be of benefit. Its chief use in these patients was as a substitute for scopolamine, the administration of which had become burdensome to the patients and had led to much wasting (cachexia). Prior to the use of mercury these patients were hardly able to exist without scopolamine. But in the great majority of chronic forms, the patients either made no improvement or gave evidence of an over-sensitiveness to mercury which prevented its further exhibition. Discussing the mode of action of mercury the author draws a parallel between lethargic encephalitis and syphilis. He inclines to the view that the drug has a curative action on the inflammatory processes, but no influence on the resulting degeneration of the nerve elements.

Elimination of Arsenic.

F. M. R. BULMER (*Journal of Pharmacology and Experimental Therapeutics*, June, 1923) published the results of a research into the distribution of organic arsenic compounds after intravenous administration to rabbits and dogs. Intravenous injections of "Phenarsenamine"—in dose relative to that of man—were given to rabbits and *post mortem* examinations were made from five minutes to ten days later. The arsenic was found chiefly in the liver, lungs, kidneys and long bones. The liver contained more arsenic than the lungs in an animal killed five minutes after injection, but an hour after injection and for several days there was more arsenic in the lungs than in the liver. One hundred and eighty-three milligrammes of "Phenarsenamine" were injected into a dog weighing 13.7 kilograms. Arsenic was found in the urine and fæces for thirty-eight days afterwards. The dog was killed on the fortieth day and it was found that the liver, lungs, heart, spleen, kidneys and femur contained considerable quantites of arsenic. Elimination of arsenic varied considerably, but it was found that generally the fæces contained more arsenic than the urine. Injections were given every seventh day to a dog and it was found that the arsenic excreted in the fæces and urine increased to a maximum on the second day and fell rapidly till the fourth day, after which the rate of excretion was much less noticeable. Other dogs received injections, the common bile duct was ligated and the fæces collected; it was found that the arsenic content of the fæces was greatly lowered. In these animals also the urine and bile were collected and the arsenic content of these secretions was found to be much increased above the normal arsenic content in dogs in which the bile duct was not ligated. The conclusion was made that the body normally eliminates arsenic chiefly through the bile and that the liver rather than the kidneys is the main arsenic clearance depôt. Since the liver often suffers in arsenic administration it was suggested that the administration of glucose along with arsenic might help to protect the liver. It is pointed out that it is an established fact that glucose protects the liver from such poisons as phosphorus.

Ether.

H. H. DALE, C. F. HADFIELD AND H. KING (*The Lancet*, March 3, 1923) record the results of their investigation into the anæsthetic action of pure ether. In 1917 J. H. Cotton and in 1921 Wallis and Hewer stated that perfectly pure ether had no anæsthetic properties. The authors prepared as pure an ether as they could which was perfectly free from aldehydes, ketones, acids, mercaptans and all other known impurities. This ether was tested on cats and found to produce anæsthesia as rapidly and efficiently and with less irritation than most commercial ethers for anæsthesia. "Ethanesal" was also tested and found to be neither better nor perceptibily worse than pure ether as an anæsthetic. The pure ether was then used to anæsthetize eight patients, all of whom were subjected to operations, some major and some minor. It was found to produce quite satisfactory anæsthesia; the induction was found if anything to be more rapid with pure ether than is usual with commercial ether. "Ethanesal" was analyzed and found to contain 95.5% ether, 4% butyl alcohol and 0.5% of a mixture of ethyl alcohol and an aldehyde; there was no evidence of the potently anæsthetic ketones which Wallis stated it should contain and to which he attributed its anæsthetic properties. The authors consider that there is no evidence that pure ether is devoid of anæsthetic action and that there are no grounds for attributing the anæsthetic properties of "Ethanesal" to any other constituent than ether.

UROLOGY.

Hydronephrosis.

W. C. QUINBY (*Journal of Urology*, July, 1923) declares that obstruction by an aberrant renal vessel is not so rare a cause of hydronephosis as has been thought. Furthermore there has been, as a rule, failure to apply the ideal reparative treatment when such a condition has been discovered at operation. The symptoms usually begin during the second decade of life. Pain is located under the costal margin or in the costo-vertebral angle posteriorly and, as a rule, it does not radiate. The attacks increase in severity and the intervals between attacks decrease as time goes on. The acute attack comes on sharply, reaches its maximum in a few hours and then subsides leaving a heavy aching sensation in the back which may last for several days. In the intervals the patient may experience a dragging feeling in the back and may find that certain bodily movements or positions are best avoided. Commonly no tumour is palpable. As a rule no unusual symptoms accompany urination. The kidney efficiency on the affected side will be found to be decreased in advanced conditions. Pyelography discloses kinking caused by the band of vessels. This band is composed of the aberrant artery accompanied by a couple of veins. The artery may be very small or may carry nearly one-half of the renal blood supply. In the latter case the operative treatment should obviously not be section of the band of vessels. When the renal efficiency on the affected side is very low, nephrectomy is the best treatment. In the majority of instances, however, an ideal reparative operation can be carried out. The possibility of success rests on the observed fact that in nearly every instance there is no stricture or valve formation in the upper portion of the ureter, but merely a kinking by the band of vessels. Transverse section of the ureter at its junction with the pelvis, followed by reimplantation into the most dependent part of the dilated pelvis, gave brilliant results in three instances. An alternative operation is the making of a short longitudinal incision along the uretero-pelvic juncture and sewing it up transversely as in a pyloroplasty.

Diverticulum of the Bladder.

J. SWIFT JOLLY (*Proceedings of the Royal Society of Medicine*, July, 1923) reports in detail the histories of fourteen patients suffering from vesical diverticulum in whom he has attempted radical cure by operation. When a definite diverticulum is present the only treatment worthy of mention is complete excision of the sac. On this point all are agreed, but there is much divergence of opinion as to the best method of performing this very difficult operation. The author condemns preliminary cystostomy which is sometimes used as a preparatory cleansing operation. When the bladder contracts around the cystostomy tube, the orifice of the diverticulum likewise contracts and closes; the sac thus becomes shut off from the bladder. In this way the condition is only made worse. When called upon in future to deal with very grossly infected diverticula he intends to open the bladder and pass two small tubes into the sac in addition to leaving a larger one in the bladder itself. Continuous irrigation of the sac covity as well as washing of the bladder can then be performed. The type of radical removal to be employed will be governed chiefly by the amount of peri-diverticulitis present. The study of cystograms before operation gives no clue to the state of the peri-diverticular tissues. The sac may be excised from the outer surface of the bladder, from within the bladder and by splitting the lateral wall of the bladder down to the orifice of the sac, cutting around the neck of the sac through the whole thickness of bladder wall and finally excising the sac. The latter method is applicable to all patients with diverticula and in the great majority is the only useful and practical procedure. It was described by the author in August, 1913, and also independently by Marion, of Paris, in November of the same year. The relationship of the ureter to the sac is of great importance. When the ureter opens into the sac itself, its orifice lies just within the lower and internal quadrant of the mouth of the sac. Behind this it is related to the lowest point of the neck of the diverticulum and then passes backwards and upwards behind the neck.

Torsion of the Spermatic Cord.

E. L. KEYES, JNR., C. W. COLLINS AND M. F. CAMPBELL (*The Journal of Urology*, June, 1923) have collected for study seven instances of torsion of the spermatic cord. The lesion is not uncommon, although less than one hundred cases have been recorded since its recognition in 1840. The condition is sometimes miscalled torsion of the testicle. The predisposing cause is undue mobility of the testicle and this is commonly associated with imperfect descent in 50% of instances. The exciting cause is almost certainly sudden contraction of either the abdominal muscles or the cremaster. The loosely attached testicle is thus twisted. The contraction may occur during effort, but a few instances have occurred during sleep. Torsion usually occurs between fifteen and twenty-five years of age. The symptoms are local pain and pain referred up the cord. Later on come redness, œdema and tenderness of the scrotum and still later nausea, sweats and prostration. The diagnosis is often not made because the observer thinks of the more common strangulated hernia or epididymitis. In the former there are progressive vomiting and constipation, while in the latter a raised temperature and involvement of the *vas deferens* and internal genitals will be noted. Unless the torsion is slight and promptly relieved, the testicle either becomes gangrenous as in 86% or it atrophies. The treatment consists in prompt operation. If the testicle is viable it should be untwisted and fixed; if it is gangrenous orchidectomy should be performed. Should the opposite testicle be too mobile, as it often is, it should be fixed.

The Effect of Chloride Ingestion on the Phenol-Sulphonephthalein Output.

M. NEGRO AND G. CALOMET (*Journal d'Urologie Médicale et Chirurgicale*, December, 1922) noticed during their testing of the renal efficiency of patients suffering from hydræmic nephritis no variation in the phenol-sulphonephthalein output during periods of considerable variation in the chloride content of the blood. They, therefore, decided to test the effect of variation of the chloride ingestion on the output of the dye. They determined that the phthalein output in normal persons remained constant while the chloride output varied directly with a salt-free and a high salt diet. Secondly, in patients undergoing bladder drainage preparatory to prostatectomy, a similar variation of the diet had no effect on the gradual rise of the phthalein output during the amelioration of the renal state, so that the phthalein chart mapped out during this period retained all its characteristic features. They conclude that chloride retention in the blood has no effect on the phthalein output, when the retention of purely renal origin. Other workers have shown that in cardiac and cardio-renal diseases the variation of the phthalein output which occurs, is due to slowing or enfeeblement of the blood current and not to any chloride variation which may be present.

Absorption from the Urinary Tract.

J. A. H. MAGOUN (*Journal of Urology*, July, 1923) has studied the problem of absorption from different parts of the urinary tract. Certain dyes and bacteria were injected separately into the renal pelves, ureters, bladders and urethræ of dogs and were collected later on, if absorbed, from one or both ureters according to the nature of the experiment. The author found that the absorptive powers of the different parts of the urinary tract manifested wide variation. The pelvis of the kidney absorbs both dyes and bacteria to a considerable extent. The ureter and the urethra absorb the dyes readily, but the bacteria less readily. The bladder, on the other hand, absorbs only a very small amount of dye and no bacteria. In considering the relative powers of absorption the kidney seems to have the greatest power with the urethra second and ureter third. It would appear both experimentally and clinically that the pelvis of the kidney, once infected, may act as the focus for metastatic infection of other parts of the body.

British Medical Association News.

SCIENTIFIC.

A MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, Adelaide Street, Brisbane, on October 5, 1923, DR. D. A. CAMERON, the PRESIDENT, in the chair.

Sarcoma of the Humerus.

DR. A. T. H. NISBET showed a radiogram and read the clinical notes of a patient who was suffering from a sarcoma of the head of the humerus. The patient, a woman aged forty-three years, had been treated for some time for rheumatoid arthritis. Vaccines had been administered without producing any good effect. On May 5, 1923, an incision had been made over the head of the humerus. The presence of sarcoma had been suspected and a portion of a growth had been removed for examination. A diagnosis of spindle celled sarcoma had been made. Dr. Nisbet had seen the patient on May 16, 1923. She had been in great pain and had required morphine at night. She had looked haggard and drawn. Deep X-ray therapy had been applied in three different areas around the humerus within the following few days. From the first day pain had been considerably relieved and since that time the patient had not required hypnotics. The arm had decreased in size. Dr. Nisbet said that instead of a broken down bone at the upper end of the humerus the arm was filling in and the bone was returning to its normal shape. It was five months since the first application of the X-rays. Four days previously the patient had been present and in order to let no chances slip he (Dr. Nisbet) had given two further applications of deep therapy. On examination by the X-rays there was no apparent deposit in the lung tissue. Except for some restricted movement of the shoulder joint, Dr. Nisbet thought that no one would know that there was any disease present. Since the first treatment the patient had gained 1.3 kilograms in weight. Dr. Nisbet thanked Dr. McLelland, of Maryborough, for permission to publish the report of the case.

Ectopic Gestation.

DR. A. H. MARKS, C.B.E., D.S.O., read a paper entitled: "Some Notes on Ectopic Gestation" (see page 1).

Diathermy and Malignant Disease.

DR. R. GRAHAM BROWN showed several patients to illustrate the effects of diathermy on malignant disease of the throat.

The first patient was a woman, aged fifty-eight years, who had suffered from a carcinoma of the left vocal cord spreading on to the right. Total laryngectomy had been performed on August 5, 1920. The wound had healed in three weeks. On November 21, 1921, diathermy had been applied to a suspicious granulation on the anterior wall of the pharynx at the attachment of the tongue to the hyoid bone. At the time of demonstration two small superficial glands could be palpated at the posterior border of the sterno-mastoid muscle at the junction of the lower and middle thirds. They were painful when touched, freely movable and had only been noticed for twenty days. Dr. Graham Brown asked for opinions as to the glandular condition. In any case he intended to remove the glands in due course. He pointed out that it was three years since the performance of the laryngectomy.

Dr. Graham Brown's second patient was a man, aged sixty-eight years. In February, 1922, he had complained that for the previous month he had suffered from a "raw" throat with severe pain up the side of the neck and down the side of the jaw. The pain had been so severe that the patient had not been able to sleep. A large superficial ulceration had been present on the right side of the soft palate and the right tonsil. There had been some extension downwards into the lateral aspect of the pharynx on the same side. No enlarged glands had been present. A specimen had been removed and sent to Professor Welsh, of Sydney, for examination. Professor Welsh had regarded the growth as a squamous carcinoma of the tonsil. On February 22, 1922, a big dose of diathermy had been applied. In April, 1922, the glands on the right side of the neck had been resected by Dr. R. A. Meek. In May, 1922, a second application of diathermy had been made to some suspicious granulations. Dr. Graham said that this ulcer corresponded to the superficial type of epithelioma described by Mr. William Trotter, who held that prognosis was good in these conditions if thorough local treatment had been carried out. It was nineteen months since the operation and no recurrence had taken place.

Dr. Graham Brown's third patient was a man, aged forty-three years, who had been referred to him by Dr. R. A. Meek. Dr. R. Graham Brown had first seen the patient in April, 1922. In 1915 Dr. Meek had removed malignant glands from the left side of the neck. He had given a bad prognosis as the glands had broken down. There had been no sign of a primary growth. A left facial paralysis had supervened some months after this operation. In 1917 a second extensive operation for recurrence had been performed by Sir Alexander MacCormick in Sydney. One week prior to the time when Dr. Graham Brown had first seen the patient there had been a spontaneous bloody discharge from the ears. There had been no history of previous bleeding or discharge. The patient had presented the appearance characteristic of one from whom the glands on the left side of the neck had been removed together with the sterno-mastoid muscle. A small granulation had been found on the posterior wall of the external auditory meatus at about one-third of the distance in towards the drum. There had been a boggy condition over the mastoid process, similar to that found in chronic periostitis. "Drying drops" had been prescribed and the patient had been carefully watched.

On May 31, 1922, after much persuasion the patient had agreed to an exploratory operation. The extent had been surprising, but in view of the low grade of malignancy, Dr. Graham Brown had decided to perform as radical an operation as possible. He had removed the whole of the mastoid process, the posterior half of the squamous portion of the temporal bone and a large portion of the occipital bone. The growth had been peeled from the *dura mater* as far as the *foramen magnum*. The lateral processes of the atlas and axis had been exposed and a connexion had been made with the scar tissue in the neck the result of the previous operations. A copious escape of cerebro-spinal fluid had occurred and with this had been associated collapse of the patient. Rapid recovery had occurred. Since that time several applications of X-rays had been made at intervals (deep therapy had not been used). The patient was feeling well and had not felt better for years.

Dr. Graham Brown said that no pathological examination had been made at the previous examinations.

DR. DUHIG in a report on tissues supplied at the recent operation was as follows:

"Epithelial cylindromatous tumour, derived probably from cells *rete malphigii*, intermediate in malignancy between squamous epithelioma and rodent ulcer."

PROFESSOR WALSH had also reported as follows:

"The tumour cells generally are all small squames, remarkably uniform in size and in shape. Most of the invading tumour cells form a confused and continuous cell-mass, without definite arrangement. But in places they fall into narrow branching columns which form a more or less open reticulum. At other places they are compacted into concentric laminated 'cell-nests,' with a tendency to degenerate in the centres. To my mind this structure and the clinical history leave it an open question whether the new growth is an endothelioma or an epithelioma. The squamous-cell type of growth is consistent with either view. If it is an endothelioma, the primary growth is probably from the endothelium of the lymph glands of the neck. If it is an epithelioma, the primary growth has probably taken origin from the basal cells of the epidermis, *id est* a basal-cell epithelioma. In that case the primary growth has been so insignificant as to escape

observation and had probably died out, before the patient first consulted a doctor. But before the tumour cells died at the primary site, some of the cells had escaped into lymphatics and had invaded the cervical lymph gland from which further secondary invasion and dissemination had occurred. The tissues invaded by this latest manifestation of the growth include dense fibrous tissue, striped muscle fibres and spicules of bone. . . . It was really a most difficult specimen to interpret, although a most interesting one."

Lymphadenoma.

DR. S. F. MCDONALD exhibited a specimen of lymphadenoma and read notes on the history of the patient by himself and Dr. D. A. Cameron. The patient, a woman, aged forty-two years, had had no previous illness until six months previously when she had been left weak and miserable by an attack of influenza. She had gone away for a holiday, but had become so ill that she had found it necessary to go to hospital and had remained there until she returned home a week before her admission to hospital in Brisbane. During this illness her feet and hands had swelled, she had become very breathless and she had suffered from an irregular fever. There had been no cyanosis and there had not been any diminution in the amount of urine. Both sides of the chest had been tapped and large quantities of milky fluid had been withdrawn. The blood had been examined for filaria without result. On admission to St. Martin's Hospital her temperature had been 37.8° C. (100° F.), the pulse rate had been one hundred and twenty and the respirations had numbered thirty to forty in the minute. A small wasted woman, she had not been greatly orthopnœic. Œdema of the hands and feet and slight cyanosis of the lips had been present. No abnormality of the teeth, tongue or throat had been present. The heart had been displaced to the left, but no cardiac murmurs had been audible. Examination of the lungs had revealed the right base to be "dead" and airless, some signs of fluid had been present. The signs at the left base had suggested the presence of collapse, no definite signs of fluid had been found. Examination had revealed a palpable liver. The spleen had not been palpable. After a good action of the bowels a hard mass had been palpable in the right iliac fossa. Apparently much fluid had been present in the abdominal cavity. There had been no enlargement of superficial glands. No abnormality had been detected in the urine. Examination of the blood had shown that the erythrocytes numbered 3,500,000 in the millimetre and the leucocytes 10,000. The hæmoglobin value had been 65%. No abnormal form had been found and no filariæ. X-ray examination had revealed a collection of fluid at the base of the right lung together with some cardiac displacement. Three days later the patient had suddenly become much worse, breathlessness had increased and she had died.

At *post mortem* examination both pleural cavities had been found full of milky fluid. About six hundred cubic centimetres had been present on the right and five hundred on the left side. This fluid had contained many white corpuscles and much fat. Except for the displacement the heart had been normal. The mediastinal contents had been densely matted together, but the glands had been comparatively small. A dark pigmented cord was all that had been found to represent the thoracic duct. The liver and spleen had been enlarged apparently from passive congestion and had contained numerous sub-peritoneal nodules. The retro-peritoneal and internal iliac glands had been greatly enlarged, some of them to the size of a closed fist. These had manifested the white character so constantly seen in the disease.

DR. DUHIG had reported that the masses were lymphadenomatous.

Gun Shot Wound of the Head.

DR. A. A. DAVIS read the clinical notes of a patient who had suffered from a gun shot wound of the head. The patient had been admitted to hospital on June 11, 1923, for treatment of a sinus, the result of a gun shot wound in the right frontal bone.

On June 12, 1923, Dr. G. P. Dixon had operated and had found a large hole in the frontal bone exposing the meninges. The inner part of the frontal sinus had been found to be full of sequestra. The anterior wall of the sinus had been packed with iodoform gauze and a rubber drain had been inserted. The patient had made a slow recovery. He had been treated as a convalescent patient for about two weeks and was frequently allowed leave during this period. He had been discharged and told to report as an out-patient on August 21, 1923. On the evening of his discharge he had been brought back by ambulance looking very ill and complaining of severe pain in the head and the back of the neck. Some rigidity of the neck muscles had been present. The knee jerks had been present. There had been no photophobia. Although the sinus was open there had been but little discharge. Occasional vomiting had been present. The following day his condition had remained the same, except that he had been able to take fluid nourishment in quantity without vomiting. Some stiffness of the neck had still been present and the pain had remained acute. It had been relieved by "Aspirin" and an occasional dose of morphine.

On August 23, 1923, Dr. E. W. Ahern had seen the patient and had advised dilatation of the sinus, inhalations and the administration of "Urotropin" by the mouth. This had been carried out. At night, however, the temperature had risen to 40° C. (104° F.) and from then onward fever of a hectic type had been present.

On August 25, 1923, at the suggestion of Dr. C. Mattei the discharge from the sinus had been examined by Dr. J. V. Duhig and a short chain of streptococci had been found. On the assumption of the presence of streptococcal septicæmia ninety cubic centimetres of anti-streptococcic serum had been given by subcutaneous injection.

On August 26, 1923, the temperature had varied from 37.8° C. to 39° C. and the pulse rate had been very rapid. It had reached one hundred and fifty-six in the minute. Pus had come in small quantity from the sinus, there had been less pain in the neck and there had been no vomiting. Fluid nourishment had been taken. The knee jerks had been present and there had been noticed a doubtful Kernig's sign. Incontinence of urine had been present since the second day of illness and he had at this stage developed rectal incontinence and had failed to retain saline solution when given in small quantities. Frequent relapses into delirium had occurred. On this day ninety cubic centimetres of anti-streptococcic serum had been given, sixty cubic centimetres by the intavenous and thirty by the subcutaneous route. A slight remission had occurred on the following day and the patient had said that he felt better.

On August 27, 1923, Dr. S. F. McDonald had been asked to examine the patient. He had found the right lung to be solid. The respirations had been as high as fifty-four in the minute. The temperature had varied from 38.4° C. to 39.4° C. (101° F. to 103° F.) and the pulse rate had been from one hundred and forty-four to one hundred and sixty-four. One hundred cubic centimetres of anti-pneumococcal serum had been given intravenously in the hope of combating a mixed infection if it were present. This had been followed by an improvement on the following day, but incontinence of the urine and fæces had still been present. Dr. McDonald had performed lumbar puncture and had withdrawn about fifteen cubic centimetres of cerebro-spinal fluid. Ten cubic centimetres of anti-streptococcic serum had been administered intrathecally. The cerebro-spinal fluid withdrawn had been under increased pressure and turbid. On examination it had been found to contain an abundance of pus cells and streptococci in pure culture. Both lungs had been explored, but nothing abnormal had been found. The pleural fluid had been straw coloured. Its quantity had not been excessive. It had not been examined microscopically. As a last resort twenty-five cubic centimetres of "Eusol" and seventy-five cubic centimetres of saline solution had been injected intravenously, but without any subsequent improvement. On August 29, 1923, the patient's condition had become hopeless and he had died the following day.

A *post mortem* examination of the brain had been carried out by Dr. Ahern and he had found a spicule of bone on the right frontal area of the brain surface. An abscess of the right frontal lobe extending into the left lobe had been discovered together with necrosis of the frontal area to a moderately large extent. The abscess had tracked through to the cerebellum and on to the bulb along the base of the brain. Much yellowish green pus had been present. Streptococci had been found in smears prepared from this pus.

In conclusion Dr. Davis pointed out that the original wound had occurred in 1917. The left eye had been blinded as a result. Twenty-six operations had been carried out for the removal of bone and pieces of the foreign body. An operation had been performed for ptosis of the left eye. In the left eye there had been rupture of the chorioid and of the retina at the macula and around it between the disc and the macula. Some optic atrophy had been present. These conditions had been due to the force of the blow and had been mainly *contre coup* effects.

A MEETING OF THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held in conjunction with Saint Vincent's Hospital Clinical Society in the Out-Patient Department of the Saint Vincent's Hospital on October 3, 1923.

Concurrent demonstrations were conducted by the members of the honorary staff of Saint Vincent's Hospital.

Osteo-Arthritis.

DR. L. S. LATHAM presented a male patient, aged fifty-four years, who had been in ill-health for two years. In the first place he had experienced sharp lancinating pains in both legs, but particularly in the right. These pains had gradually increased in severity and had been followed by loss of power in the limbs which affected the right lower limb to such an extent that it frequently collapsed under the weight of the body.

During the five weeks prior to the patient's admission to hospital the pain and weakness had become much aggravated and he had further complained of a sensation of numbness in the right leg and a feeling that he was walking on cotton wool. He had stated that if he looked at an object for any length of time it appeared double.

He had been treated for gonorrhœa and a penile sore at the Public Health Clinic two years previously. According to the patient's own statement his blood had been tested (presumably the Wassermann test was applied) eight times and a "negative" finding had been returned on every occasion. Dr. Latham pointed out that on physical examination a general loss of weight was evident. Advanced wasting was observed in the muscles of the right lower limb affecting particularly those above the knee joint and power in the right limb was definitely diminished as compared with the left. In the course of examination for the detection of sensory changes a zone of hyperæsthesia was delineated immediately below and around the right knee joint and a similar zone was charted at the junction of the proximal and middle thirds of the right thigh. The patient was unable to discriminate between one and two points on either lower limb. In the upper limbs the tendon reflexes of the biceps, triceps, supinator and pronator muscles were active and no difference could be detected in a comparison of the two sides in this respect. Similarly the tendon jerks at the knee and ankle joints were very active and equally so on both sides. The plantar reflex was extensor in character on both sides, while the superficial abdominal reflexes were absent on the left side and could be elicited with difficulty on the right side. The systolic and diastolic blood pressure registered one hundred and sixty and one hundred millimetres of mercury respectively and the pulse pressure was sixty millimetres of mercury. Dr. Latham also said that the cerebrospinal fluid had failed to react to the Wassermann test. It had contained 0.7% of albumin and occasional red blood cells and leucocytes had been found. When a sample of blood was sent recently for investigation by the Wassermann test a return of "partial reaction" had been received.

The radiographer's report was that the skiagram revealed advanced osteo-arthritic changes about the lumbar spine, right hip joint and left knee joint. In the latter situation unmistakeable lipping of the bones entering into the articulation was evident.

DR. C. GORDON SHAW showed a patient, a woman aged forty-seven years, who eighteen years previously had sprained her right knee. The injury had been followed by much pain and swelling in the joint and had caused her to be confined to bed for six weeks. Since the accident there had been periodic recurrences of pain and swelling in the right knee and occasionally the joint had become locked. For the previous three months the pain had been continuous. On examination the joint was found to be swollen and bony ridges were palpable on the femur and tibia; there was no limitation of movement.

Schlatter's Disease.

A boy, aged eleven years, had appeared in Dr. Shaw's out-patient clinic on August 9, 1923. For a week prior to that date he had noticed a tender swelling just below the left knee and he had given a history of injury to that region by a chisel four months previously.

Examination had revealed a tender swelling over the tubercle of the tibia. At the time of demonstration the knee had been in plaster for six weeks.

Aortic Regurgitation.

DR. L. S. LATHAM showed a patient, a youth of twenty years, who had contracted acute rheumatism three years previously. During that illness he had been confined to bed for a period of seven months. Since that time he had been seriously embarrassed by shortness of breath, severe headaches, tinnitus and attacks of vertigo. He had been obliged to restrict himself to light work and the immediate cause of his admission to hospital had been a fainting attack which occurred three weeks prior to the date of the meeting.

The apex beat had been found in the sixth intercostal space at a point 14.4 centimetres from the mid-sternal line. A diastolic thrill had been palpable over the præcordial area and by percussion the cardiac dulness had been found to extend three centimetres to the right of the sternum. The pulse, of collapsing character, exhibited a dicrotic wave and capillary pulsation was well illustrated.

At the aortic area systolic and diastolic murmers were audible and were conducted into the large vessels of the neck and arm; a systolic bruit was also present in the mitral area.

A pistol shot sound and systolic murmur were well heard on auscultation over the femoral vessels.

On ophthalmoscopic examination this patient provided an excellent example of pulsating retinal veins. His systolic blood pressure registered one hundred and eighty-four millimetres of mercury and the diastolic eighty in the right arm. The corresponding figures for the left arm were one hundred and ninety-six and one hundred millimetres of mercury. The pulse pressures in the right and left arms were one hundred and four and ninety-six millimetres of mercury respectively.

Hodgkin's Disease.

DR. A. E. ROWDEN WHITE exhibited a patient affected with Hodgkin's disease. A male, aged seventeen years, had been admitted to hospital by reason of a swelling which had been present in the left side of the neck for several months. Otherwise he had been well. A group of glands had been removed in June, 1923, but since the operation other groups of enlarged glands had appeared in the neck, axillæ and inguinal regions. An enlarged gland could be palpated on the dorsum of the right shoulder. The affected glands were discrete and movable. Splenic enlargement was of a degree sufficient to render the organ readily palpable. No diagnostic features had been observed in a detained examination of the blood,

but a histological section of an excised gland had strongly suggested Hodgkin's disease.

Since the boy's admission to hospital the glandular swellings in the neck and axillæ had occasioned him a great deal of pain which had been relieved by irradiation with X-rays. Pain in the region of the spleen also had been troublesome. The patient had become much more pallid in appearance, progressively asthenic and latterly had had sustained periods of pyrexia. Several attacks of epistaxis had occurred during the previous three weeks.

Dr. White exhibited radiographic films of the thorax in which enlargement of the mediastinal glands was well shown. The radiologist had reported pulsation, synchronous with that in the aorta, in the mediastinal mass.

An examination of the blood on July 23, 1923, had revealed that the red cells numbered 6,900,000 in each cubic millimetre, the leucocytes 30,000 and the hæmoglobin had been 100%. On October 2, 1923, the findings had been: Red cells, 4,610,000 per cubic millimetre, leucocytes 23,800 per cubic millimetre and anistocytosis, poikilocytosis and poor staining had been noted in the film. The various types of leucocytes had been represented thus: Neutrophile polymorpho-nuclear cells 83%, lymphocytes 4.4%, mononuclear leucocytes 4.9%, endothelial cells 2.2%, eosinophile polymorpho-nuclear cells 2.5%, basophile cells, 0.4%.

Tuberculous Lymphadenitis.

In the second instance Dr. White presented a youth, aged nineteen years, who had sought advice on account of a swelling in his neck which he stated had been gradually increasing in size for the previous twelve months. Two or three weeks after he first became aware of the swelling the patient had suffered from a "sore throat" of several weeks' duration. Latterly he had experienced a choking sensation in his chest during cold weather and after exertion. He had noted that his voice acquired a harsh quality when he lay down. He had been troubled with a slight cough for an indefinite number of years. He had suffered no pain, had experienced no night sweats and had not lost weight. He had expressed himself as feeling as well and healthy as he had ever been.

On physical examination enlarged discrete glands had been apparent in the neck on both sides, in the right axilla, right forearm and both inguinal regions. The signs of pathological change had been detected on physical examination of the chest. The spleen had been just palpable.

An examination of the blood at the time of the patient's admission on September 7, 1923, had revealed that the red cells numbered 6,500,000 per cubic millimetre; no abnormal features had been noted in the film. On October 2, 1923, the red corpuscles had been recorded as 5,965,000 per cubic millimetre, hæmoglobin value 100% and leucocytes 7,100 per cubic millimetre. A differential count of the white cells had revealed no abnormality. The blood serum had failed to react to the Wassermann test. An enlarged gland had been excised from the right arm and submitted for pathological examination. In the report it had been stated that the section revealed caseation, giant cell formation and fibrosis and the opinion had been expressed that the process was tuberculous. A second gland had been excised from the neck and the pathological report had been to the effect that the gland tissue was replaced by very numerous atypical giant cell systems. The section had also exhibited much fibrous tissue and small areas of caseation. This had also been interpreted as indicating tuberculous changes. Radiographic examination of the chest had been carried out, but nothing helpful in regard to diagnosis had been discovered.

Goître in its Relation to Infection.

DR. SYDNEY PERN had assembled some twenty patients as illustrating the relationship between goître and infective foci.

Mrs. X., aged thirty-four years, had undergone an operation for exophthalmic goître about four years previously and had gained a certain amount of temporary benefit. Three years later a further operation for the removal of gall stones had been performed, but during the last twelve months her general health had become steadily worse and all the former symptoms of goître had been much in evidence.

When examined on May 2, 1923, the patient's tonsils had been found to be enlarged and infected and her pulse rate had been one hundred and twenty-four. Tonsillectomy had been performed and it had also been found necessary to remove the very enlarged lingual tonsils. A degree of improvement, not altogether satisfactory, had followed this operation.

In the light of some suspicious looking sores on the patient's legs and the fact that a partial reaction had been obtained to the Wassermann test, anti-syphilitic treatment had been instituted, but no improvement could be observed in the symptoms referable to exophthalmic goître.

Operation had been again recommended, but the surgeon had declined the risk.

On June 7, 1923, after careful questioning of the patient it had been found that there was some evidence of nasal infection and treatment of this had been followed by immediate improvement. This improvement had been maintained and the patient's weight, formerly fifty kilograms had increased to sixty-two kilograms. She was quite strong and was doing all her own house work.

Dr. Pern emphasized the fact that in this patient the nasal infection would not have been discovered unless attention had been directed especially towards it.

A second woman, aged thirty-seven years, had received surgical treatment for exophthalmic goître thirteen years previously and although some amelioration of the symptoms had followed, the exophthalmos had not been appreciably diminished. For the past seven years her eyes had been so prominent that she had been unable to close the lids and she had in consequence suffered much pain and inconvenience from ophthalmia. This patient had also been troubled by diplopia and had suffered severe and almost continuous headaches. Within a week of the commencement of treatment for her nasal infection the headaches had left her completely and the diplopia had vanished. The eye balls had steadily receded. The patient had gained two kilograms in weight in the previous four weeks and the pulse rate had steadied from ninety-six to seventy-four in the minute.

Among Dr. Pern's other patients was a woman, aged forty years, in whom a goître had been present for six years. She had suffered from thyreo-toxic symptoms, such as distressing palpitation, severe headaches and tremor with a pulse rate of one hundred and twenty. Her general health had been vastly improved; the pulse rate was eighty-eight and she had gained considerably in weight. The goître was much softer in consistence than formerly and was diminishing in size. On account of former persistent yellow post-nasal discharge resection of the nasal septum had been performed and treatment instituted for sinusitis.

Hypophyseal Dystrophy.

DR. NORMAN LORIMER showed a male patient, aged sixty-six years, who furnished a very good example of hypophyseal dystrophy. He stated that he had been healthy as a child, but that his legs had always been long in proportion to his body. He was of female facial appearance and had a high-pitched voice; although the hair on the head was abundant, it was sparse elsewhere. The head was small, the lower jaw prominent, the hands large and the skin soft and delicate. Fat distribution was notable in the region of the breasts, hypogastrium, buttocks and thighs. Genital hypoplasia was extreme.

Dr. Lorimer exhibited charts of the visual fields and the curve of blood sugar. From these it was seen that the fields of vision were normal and that there was no alimentary glycosuria. The patient's intelligence was above normal; he was a cabinet maker by occupation and had developed asthma during the previous seven years. The asthmatic condition was probably to be referred to the irritation of saw-dust and infection from septic teeth.

Mammary Hypertrophy.

DR. D. MURRAY MORTON showed a girl on whom he had operated for the relief of very great inconvenience caused by excessive mammary development.

He detailed the operation, performed in two stages, by which he had removed 1.6 kilograms of gland tissue and skin from each side and had conserved the nipple and areola.

Sarcoma of the Humerus.

MR. H. B. DEVINE presented a woman, aged thirty-eight years, who prior to treatment had exhibited an extensive brawny induration of the left arm and shoulder extending from below the elbow to the chest and root of the neck. The swelling had developed gradually during the previous six months and had been accompanied by a great deal of pain. No history of trauma had been obtainable, but it had been elicited that pain, attributed to neuritis, had been present for eighteen months prior to the appearance of swelling. Both elbow and shoulder joints had been fixed and rigid so that the whole limb was rendered useless.

Radiographic examination had revealed tumour formation involving the greater part of the humerus and indicated certain changes in the central portion.

Dr. Brennan's report on the piece of tissue excised and submitted to him was as follows: "Piece of tissue taken from the region of the deltoid muscle shows a fibrous reticulum with numbers of small spindle and round cells strongly suggestive of sarcoma."

The Registry of Bone Sarcoma in the United States had classified the tissue as endothelioma (Ewing). A diagnosis of sarcoma of the humerus had been made from clinical, radiographic and histological appearances, but owing to the extent of the neoplasm even a scapulo-thoracic amputation had been out of the question.

On July 27, 1922, Dr. H. Flecker had applied a single intensive dose of X-radiation, a voltage of 200,000 being employed. Eight days later the patient had been much excited by the decided reduction in the size of the growth. By August 10, 1922, the swelling had not only almost disappeared, but the pain and stiffness had so diminished that she was able to do up her hair. On September 8, 1922, her weight had increased by five kilograms. On November 17, 1922, she had been able to play the piano at an entertainment. She had had two doses of X-rays, the second having been given as a precautionary measure on September 13, 1922, over a year before demonstration.

Fulminating Goitre.

Mr. Devine's second patient was a young woman who had been admitted to hospital on account of goitre and enormous protrusion of the eye balls. The surface of the cornea had been dull and ulcerated, there had been lack of tension in the anterior chamber and pus had been present in the anterior chamber of each side. The goitre, hardly obvious, had been extremely vascular and of about three or four months' duration. The eyelids had been stitched together by Dr. Edward Ryan and immediate thyreoidectomy had been performed in two stages at ten days' interval. The thyreoid gland had been so vascular that it gave the impression at operation of a tumour of blood vessels.

The histological section had revealed great hyperplasia, a tendency to papillary formation within the acini and much spoiling of the cells. Great vascularity and foci of small round cells scattered throughout the section had also been noted.

Pyloric Carcinoma.

Mr. Devine exhibited a specimen of malignant disease of the pylorus which he had removed from a man aged twenty-nine years. The patient who had been a heavy spirit drinker since childhood, had sought relief from severe pain which he felt in the epigastrium and was induced by taking food. More or less pain had constantly been present, but as a rule it had been much aggravated immediately after a meal. Vomiting had been particularly prone to occur if the patient lay on his right side, but there had been no hæmatemesis. He had suffered a good deal from flatulence and had reached the stage at which he could take milk foods only. A small tumour, hard and slightly tender, had been palpable at a point midway between the umbilicus and the ensiform cartilage.

Bilateral Hydronephrosis.

DR. JULIAN SMITH discussed the case of a woman, aged sixty years, upon whom he had operated for the relief of double hydronephrosis. This condition had been the result of ureteric stenosis which was, so far as could be determined, of congenital origin. Although the blood urea had been determined as one hundred milligrammes per one hundred cubic centimetres of blood, the patient had made a good convalescence and had left hospital with a double nephrostomy opening. The urea concentration test had been carried out on several occasions and the maximum amount of urea found in samples of urine collected at the end of the second hour after the ingestion of urea had been 0.8%. After the injection of indigo-carmine one and three-quarter hours had elapsed before the coloration appeared in the urine.

Rupture of the Ovary.

DR. J. FORBES MACKENZIE showed a specimen of ovary in which a luteal cyst had ruptured into the peritoneal cavity. The patient had become acutely ill and had presented features which led him to operate and to anticipate either acute appendicitis or tubal rupture consequent on extra-uterine fœtation. He had found a large quantity of blood in the pelvis and in the right side of the abdominal cavity. The source of the hæmorrhage had been the ruptured luteal sac in the demonstrated specimen.

Injury to the Skull.

In the second instance Dr. Mackenzie discussed the possibility of depressed fracture of the skull in a patient who had exhibited various cerebral symptoms. There was a scar in the scalp at the site of an incision of a former abscess and it was possible that the symptoms were due to involvement of a nerve in the cicatrix.

Osteo-myelitis of the Ilium.

Dr. Mackenzie also demonstrated the clinical features presented by a patient affected with osteo-myelitis of the medial surface of the crest of the ilium.

Chronic Arthritis.

DR. C. GORDON SHAW demonstrated a female patient, aged nineteen years, whom he had seen for the first time on September 24, 1923. She had then made complaint of pain and stiffness in the right hip joint, stating that she had fallen downstairs fourteen days previously and had not walked since on account of the pain. The patient had given a history of rheumatic fever two years previously. In this illness the right hip joint had been involved and she had been confined to bed for four months. Since that time she had walked with a limp and the hip joint had never been quite well.

Examination revealed flexion and adduction deformity of the right hip joint. All the movements were limited and there was considerable wasting of the muscles of the thigh.

A Problem in Diagnosis.

DR. H. BUSH invited suggestions regarding diagnosis in the case of a girl, aged fifteen years, who, never very strong, was stated to have had a hard, sputumless cough for the previous nine years.

Three months before demonstration she had complained of pain and tenderness all over the right side of the chest, but this had not been accompanied by an increase in the severity of the cough. One month later a lump had appeared on the right side of the chest; it had been tender and had proved to be progressive in size.

As far as was known there had been no fever.

Examination revealed the presence of a lump over the position of the eighth rib in the axillary line; it was not

very tender. Percussion dulness extended all over the right side of the chest and was accompanied by very great diminution in the breath sounds. These signs were apparent as high as the second intercostal space. The heart was not greatly displaced. The radiographic picture revealed a very dense well-defined shadow over an area corresponding roughly to the percussion dulness. The patient's blood had been sent for the complement fixation test with reference to hydatid, but no report had been received at the time of the meeting.

An Injury to the Elbow Joint.

Dr. Bush also demonstrated a patient who had sustained a severe injury to the left elbow joint on April 5, 1923. He had seen a doctor at the time and a dislocation of the elbow joint had been reduced.

When he came under observation at Saint Vincent's Hospital on August 22, 1923, it had been possible to extend the elbow almost completely, but flexion had been limited to a right-angle and had been very painful. The movements of pronation and supination had been absent, the forearm being fixed in mid-position. The radiographer had reported a fracture of the head of the radius which was completely separated from the shaft and lay rotated within the elbow joint.

Operation through a lateral incision had been performed on August 24, 1923, when the head of the radius was found wedged in a position medial to the tendon of the biceps and removed. Even then there had been a poor degree of flexion and it had been found that the anterior surface of the proximal third of the radius was impinging on the humerus. An anterior slice had been taken off this portion of the radius. In the after-treatment massage and self movements had been commenced early.

Multiple Papillomata of the Mouth.

DR. E. PRENDERGAST exhibited a male patient, aged sixty-seven years, who first had come to Saint Vincent's Hospital six weeks previously, complaining of a "sore mouth."

There had been observed on the under surface of the tongue an oval, snow-white plaque and over the palate a number of small superficial ulcers. In front of the left anterior faucial pillar there had been a papillary growth which was determined to be a papilloma by microscopical examination after removal. The patient's blood had not reacted to the Wassermann test.

For the previous five weeks the patient had experienced dyspnœa and difficulty in swallowing. There was considerable enlargement of the cervical lymphatic glands, while emaciation and *fœtor oris* were prominent features.

Trachoma.

MR. EDWARD RYAN discussed the case of a Greek patient who had been continually under treatment for trachoma in Greek and other hospitals for twenty-three years. The whole of the conjunctiva, both palpebral and ocular, manifested extreme argyriasis, the membrane of one eye being of an inky blackness. Tarsectomy had been performed in one eye since the patient first began to attend Saint Vincent's Hospital, but nitrate of silver drops were in use almost constantly.

Mr. Ryan also showed a male patient affected with trachoma of long standing. There had been an unusual development of lymphoid tissue in the lower fornix. Drops had been instilled for a number of years.

Pulsating Exophthalmos.

Mr. Ryan's second patient was shown in conjunction with Mr. H. B. Devine. A woman, aged fifty-four years, gave a history of a fall as a result of which she struck her lower jaw against a step. She had not lost consciousness, but had noticed a roaring sound in her right ear. She was always conscious of the noise, but at times it became aggravated; it could be heard by applying the ear to the right side of the patient's head and was synchronous with the heart heat. Fourteen days after the injury the right eye had began to protrude and had become red. Pressure on the right common carotid artery caused both noise and pulsation to cease and at the same time the patient experienced sensations of numbness and tingling in the left arm and hand. The retina on the affected side was hyperæmic, but not extremely so and the outlines of the discs were quite clear. The eye was visibly pulsating, but not to the same extent as had been the case formerly.

It was proposed to ligate the internal and external carotid arteries on the affected side, but the patient had not consented to any operation.

Myopia.

Mr. Ryan presented a woman, aged thirty years, who had had no vision in the right eye and about sixteen diopters of myopia in the left eye. This eye had been needled with a good visual result.

Albuminuric Retinitis.

Mr. Ryan demonstrated an advanced degree of albuminuric retinitis in a woman, aged thirty-five years. Extreme œdema of the retina and optic disc was manifested.

Congenital Blindness.

In another of Mr. Ryan's patients a boy, aged nine years, blindness, apparently of congenital origin affected both eyes. Hypermetropia of eight diopters was present. The eyes were small and nystagmus was obvious. The boy was said to be unsually intelligent and have been born prematurely.

The quick nystagmoid movements made examination difficult, but the disc was seen to be very pale and the general appearance of the retina was that of punctate chorioido-retinitis.

Laryngeal Papilloma.

DR. J. M. BAXTER presented a young woman who had undergone about twelve years previously the operation of thyreotomy for the removal of a papilloma of the larynx. As a result of the operation symptoms had been relieved, but the voice had never risen above a whisper. Twelve months previously the patient had begun to suffer slight suffocative attacks. In May, 1923, thyreotomy had again been performed, a papilloma removed and the larynx swabbed with absolute alcohol. About one month before demonstration the patient had gradually recovered her voice.

Laryngeal Diphtheria.

In Dr. Baxter's second patient, a woman, aged twenty-four years, late results of laryngeal diphtheria were seen. At two years of age she had contracted diphtheria. Intubation and high tracheotomy had been unsuccessful in giving the relief which was eventually secured by low tracheotomy. She was suffering from attacks of dyspnœa which had embarrassed her periodically for the last twelve years. In the condition of the larynx there was some impairment of cord movement and distortion and over-lapping of the arytenoid cartilages.

Deficiency of Septum Nasi.

Dr. Baxter's third patient was a woman who had had an operation performed on the nasal septum fourteen years previously. There was complete absence of the whole of the anterior third of the septum. Her blood serum had been investigated by the Wassermann test, but no reaction had been obtained.

Exhibition of Skiagrams.

DR. HUBERT M. HEWLETT displayed to excellent advantage a large number of very interesting skiagrams. Included among the subjects illustrated were pneumo-thorax, pyloric carcinoma, bilateral Perthes's disease, duodenal ulcer, gall stones, pyelography and coloptosis.

MEDICO-POLITICAL.

AT the meeting of the Council of the Victorian Branch of the British Medical Association, held on December 19, 1923, the following were elected office bearers:

President: Dr. J. W. Dunbar Hooper.

Vice-Presidents: Dr. Stanley Argyle, M.L.A. and Dr. D. Douglas Stephens.

Honorary Secretary: Dr. F. L. Davies.

Honorary Treasurer: Dr. C. H. Mollison.

Chairman of Committees: Dr. J. Newman Morris.

Honorary Librarians: Dr. W. G. D. Upjohn and Dr. W. S. Newton.

The following were coopted to the Council under Rule VII. of the Branch:

Dr. J. R. Harris, M.L.C., Dr. W. S. Newton and Dr. C. L. Park.

Public Health.

DIRECTOR OF HEALTH IN NEW GUINEA.

THE Department of Home and Territories is seeking applications from members of the medical profession for the position of Director of Public Health of the Territory of New Guinea. The headquarters of the Director will be at Rabaul. The salary offered is £1,200 *per annum*. The Director will not be allowed to conduct private practice. The appointment will be for not less than two years. The Department will pay the fare of the Director to Rabaul.

Applicants should have experience in the treatment of tropical diseases and should possess good organizing ability. They will be required to furnish full particulars of their age, marital state, war service, general qualifications and actual experience.

Australasian Medical Congress (British Medical Association).

Corrigenda.

IN the summary of the discussions at the Australasian Medical Congress (British Medical Association) a few mistakes have been made. In the record of the proceedings of the Section of Diseases of Children, Dr. Douglas Galbraith (page 647) in dealing with congenital syphilis informs us that he said: "The question has been raised whether it is worth while going on treating these children with a persistently positive Wassermann reaction. Personally I am of the opinion that it is, because, if the test be done quantitatively, it is found that whilst still remaining positive, the degree of positivity gradually diminishes under treatment." In the last sentence of the same paragraph the word "impossible" should read "possible."

Dr. R. M. Downes, in speaking of the treatment of glandular tuberculosis in children, said that there were few children in whom the cervical glands could not be palpated. Again in regard to surgical treatment primary excision should be carried out except in the case of infants, unless the patient lived under good hygienic conditions and could be kept under observation. In advocating surgical treatment of pyloric stenosis as soon as the diagnosis was made, he attached the proviso that the baby be in poor condition.

Dr. L. B. Elwell calls our attention to the fact that the statement: "He followed Dr. Camac Wilkinson's method, but had used smaller doses" (December 8, 1923, page 594) is misleading without the further qualification that the initial dose employed was smaller, but not the final dose.

On page 622 there is an example of a curious confusion of sound. Dr. N. B. Charlton read a paper entitled: "Bowel Parasites of Australia and her Dependencies." Our reporter caught the sentence as "Rabaul Parasites."

Medical Societies.

MEDICAL DEFENCE SOCIETY OF QUEENSLAND.

THE annual meeting of the Medical Defence Society of Queensland was held on December 14, 1923. The following is the annual report of the Council of the Society.

Annual Report of Council for 1923.

Membership.

The Society has now a membership of one hundred and ninety-six as against one hundred and seventy-one last year. During the year thirty-three new members were elected, six left the State, one resigned and one death occurred. We regret to record the death of Dr. A. P. Ross, Wynnum.

Office Bearers.

Office bearers elected for 1923 were as follows:

President: Dr. T. R. McKenna.

Vice-President: Dr. A. B. Carvosso.

Honorary Treasurer: Dr. A. H. Marks.

Honorary Secretary: Dr. R. Marshall Allan.

Auditor: Mr. R. G. Groom, F.C.P.A.

Council: Dr. J. Espie Dods, Dr. W. N. Robertson, Dr. W. F. Taylor, Dr. Wilton Love, Dr. D. A. Cameron, Dr. A. Stewart, Dr. Kerr Scott.

Medico-Lega..

Your Council has to report that no legal cases were dealt with during the year.

A claim for damages in connexion with a burn received whilst under an anæsthetic was made against a member. He had performed the operation for another doctor and had had nothing to do with the after treatment. The Council took the matter up on behalf of the member and nothing further was heard.

A member requested the moral support of the Society for alleged negligence. As the case arose prior to the member joining the Society, our Solicitors advised that this could not be given under the Articles of Association.

Taxation—Sale of Practice.

In 1921 the State Income Tax Commissioner charged a member with income tax on the full amount obtained from the sale of his practice without allowing for goodwill. After consulting our Solicitors an objection was lodged on behalf of the Society. Two years later the Commissioner allowed the claim. This has created a useful precedent.

Assets.

The total assets now amount to £1,507 15s. 8d. During the year the sum of £100 was invested in Queensland Government Treasury bonds at an interest of 5½%.

T. R. MCKENNA, President,
R. MARSHALL ALLAN, Honorary Secretary.

Financial Statements.

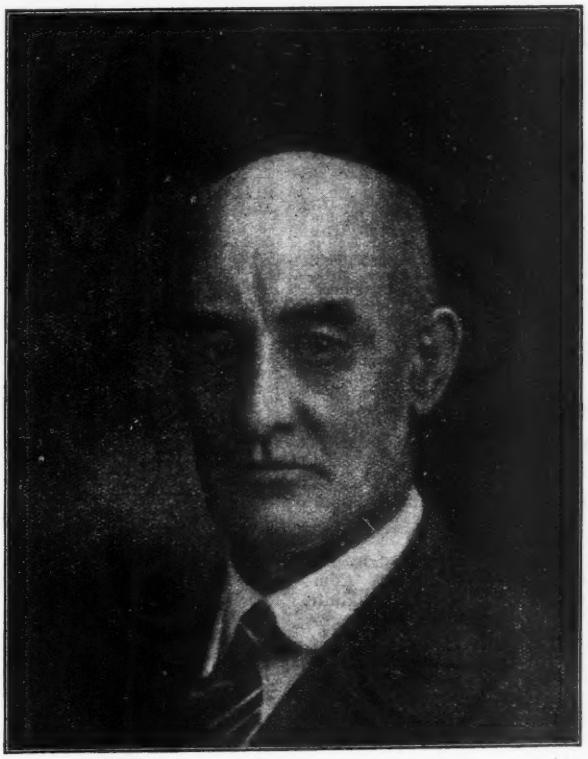
From the Treasurer's statement for the year ended November 30, 1923, it appears that the income amounted to £306, including entrance fees of thirty-four new members, subscriptions, exchange, dividends and interest. The expenditure amounted to £40 16s., including £11 2s. for legal expenses. The balance sheet reveals assets aggregating £1,507 15s. 8d. The money invested has been increased by £100. The balance of income over expenditure for the twelve months was £165 4s.

Obituary.

WILLIAM THOMAS CHENHALL.

IN the middle of November William Thomas Chenhall delighted his old Victorian friends and relatives by devoting as much time as he could spare during the Congress week to social recreation. He appeared in excellent health and displayed much energy and activity. On December 9, 1923, he was taken ill with pneumonia and on the sixth day of the struggle death gained its relentless victory.

William Thomas Chenhall was born at Chiltern in Victoria in the year 1864. He received his school education at the Beechworth Grammar School and in due course he passed on to the University of Melbourne to study medicine. At school and at the University of Melbourne he proved himself a diligent pupil and a pleasant companion. He took little prominent part in sport, although he was fond of rowing and showed aptitude in other directions. For a time he was in residence in Ormond College where he gained a scholarship. In his third year he gained a prize in anatomy and when he graduated as a bachelor of medicine and bachelor of surgery in 1892 he carried off first class honours. His registration was effected in Victoria on November 21, 1892. Five months later his name was entered on the register of medical practitioners of New South Wales. He started practice at Marrickville, but within a short time he moved to Stanmore where he carried on a successful and increasing general practice. His sound knowledge of his profession, combined with his natural aptitude, his urbanity and his innate kindness, compelled many to seek his aid and inspired confidence and affection on the part of all who entrusted their health to his charge. During the course of the ten years of this phase of his activities he felt drawn more and more toward that branch of medicine which concerns women. He worked assiduously at gynæcology and rendered himself very expert in its surgical aspects. While he was still in general practice he took rooms in Macquarie Street, in the process of transition to his elected specialty. In 1897 the Sydney University admitted him *ad eundem gradum* as a bachelor of medicine. In 1903 he relinquished his practice in Stanmore and paid a visit to the old country with his family. He had married Miss E. A. Tillock in 1896. While in Edinburgh he secured the Fellowship of the Royal College of Surgeons of that city. Before leaving Australia he had obtained the degree of doctor of medicine at the University of Melbourne. He returned to Sydney in 1904 and restricted his practice exclusively to diseases of women. His reputation had already been established and in consequence he evaded the trying period of waiting. His colleagues recognized his worth and his special knowledge and skill in this branch of surgery and were not slow in referring patients to him. In 1910 he was appointed Honorary Surgeon to the Royal Hospital for Women, a position which he held with credit to himself and advantage to the patients and the institution until his death. He strained every nerve to enhance the value of the hospital for the public and his endeavours were crowned with unmistakable success. He had become a member of the New South Wales Branch of the British Medical Association in the early part of 1894 and had been a regular attendant at the scientific meetings. For many years he had contributed papers to these meetings from time to time and in this way his colleagues had had an opportunity of judging his merits and of appreciating the serious manner in which he regarded his life's work. He contributed many articles to the *Australasian Medical Gazette* and during the past ten years to this journal. He read papers at various Australasian Medical Congresses, including one read at the first session of the Australasian Medical Congress (British Medical Association) at Melbourne. His written and spoken work was always clear and precise and its teaching value is undeniable. His articles comprise descriptions of clinical observations, new operative procedures, many of which are characterized by ingenuity and an appreciation of sound surgical principles, and endeavours to raise the general level of gynæcological work. At times his contributions gave rise to controversy. William Thomas Chenhall always conducted these arguments with dignity and consideration and avoided personalities, incriminations and self-laudation so common in these days.



In addition to his purely medical work, he was associated with several undertakings, although he was scarcely tempted to dive deeply into them. He was a member of the Millions Club and recently one of its Vice-Presidents. He belonged to the Royal Sydney Yacht Squadron and in March, 1923, he was elected a member of the Royal Colonial Institute (New South Wales Branch).

His home was his favourite club and as a family man he was pre-eminent. An ideal husband and father, he gave all the time he could spare from his work to his wife and son. The sincere sympathy of the medical profession is extended to both.

Medical Prizes.

ALVARENGA PRIZE.

THE College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize will be made on July 14, 1924, provided that an essay deemed by the Committee of Award to be worthy of the Prize, shall

have been offered. The value of the Prize is about three hundred dollars.

Essays submitted may be upon any subject in medicine. Articles that have been published will not be accepted. The essays must be typewritten and if in a language other than English, should be accompanied by a translation into English. They must be received by the Secretary of the College on or before May 1, 1924. They must be sent without signature, but marked with a motto. In an accompanying sealed envelope bearing the same motto on the outside, the name and address of the author should be enclosed.

The Alvarenga Prize for 1923 has been awarded to Dr. Edward P. Hiller, Kansas City, Missouri, United States of America, for an essay entitled: "Treatise on Echinococcus Disease." The Secretary of the College of Physicians of Philadelphia is Dr. John H. Girvin, 19, South Twenty-second Street, Philadelphia, Pennsylvania, United States of America.

Books Received.

A MANUAL OF PROCTOLOGY, by T. Chittenden Hill, Ph.B., M.D., F.R.C.S.; 1923. Philadelphia and New York: Lea and Febiger; Post 8vo., pp. 279, with 84 illustrations. Price: $3.25 net.

DIATHERMY AND ITS APPLICATION TO PNEUMONIA, by Harry Eaton Stewart, M.D.; 1923. New York: Paul B. Hoeber; Crown 8vo.; pp. 226, with 45 illustration and 15 charts. Price: $3.00 net.

DISEASES OF THE SKIN, by Frank Crozer Knowles, M.D.; Second Edition, thoroughly revised; 1923. Philadelphia and New York: Lea and Febiger; Demy 8vo., pp. 610, with 229 illustrations and 14 plates. Price: $6.50 net.

FRACTURES, COMPOUND FRACTURES, DISLOCATIONS AND THEIR TREATMENT, by John A. C. Macewen, M.B., C.M., B.Sc.; Second Edition; 1923. Glasgow: Maclehose, Jackson and Company; Sydney: Angus and Robertson, Limited; Crown 8vo., pp. 350, with 46 illustrations and 66 diagrams in the text.

HANDBOOK OF SURGERY, by George L. Chiene, M.B., C.M., F.R.C.S. (Edin.); 1923. Edinburgh: E. & S. Livingstone; Sydney: Angus and Robertson, Limited; Crown 8vo., pp. 603, with 109 illustrations.

Medical Appointments.

DR. N. R. DOYLE (B.M.A.) has been appointed Public Vaccinator at Hamilton, Victoria.

* * * *

DR. H. F. SHORNEY (B.M.A.) has been appointed by the Government of South Australia as an Honorary Commissioner to inquire into and report upon ophthalmic matters in Great Britain and the Continent of Europe.

* * * *

THE undermentioned have been authorized by the Board of Health of New South Wales as inspectors under the *Cattle Slaughtering and Diseased Animals and Meat Act, 1902*: DR. W. J. FERGUSON (B.M.A.), at Ariah Park; DR. P. M. O'REILLY (B.M.A.), at Eugowra; DR. E. A. SANBROOK (B.M.A.), at Sutherland.

* * * *

THE following appointments have been made at the Royal Alexandra Hospital for Children, Camperdown, New South Wales: DR. M. J. PLOMLEY (B.M.A.), as Honorary Physician; DR. L. H. HUGHES (B.M.A.), as Honorary Assistant Physician; DR. G. C. WILLCOCKS (B.M.A.), as Honorary Relieving Assistant Physician.

Medical Appointments Vacant, etc.

FOR announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xviii..

ADELAIDE CHILDREN'S HOSPITAL: Two Resident Medical Officers.

ALFRED HOSPITAL, MELBOURNE: Vacancies on the Honorary Medical Staff.

GEELONG GRAMMAR SCHOOL, VICTORIA: School Doctor.

ROYAL HOSPITAL FOR WOMEN, SYDNEY: Honorary Surgeon.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney	Australian Natives' Association Ashfield and District Friendly Societies' Dispensary Balmain United Friendly Society's Dispensary Friendly Society Lodges at Casino Leichhardt and Petersham Dispensary Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney Marrickville United Friendly Societies' Dispensary North Sydney United Friendly Societies People's Prudential Benefit Society Phœnix Mutual Provident Society
VICTORIA: Honorary Secretary, Medical Society Hall, East Melbourne	All Institutes or Medical Dispensaries Australian Prudential Association Proprietary, Limited Mutual National Provident Club National Provident Association
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane	Brisbane United Friendly Society Institute Stannary Hills Hospital
SOUTH AUSTRALIA: Honorary Secretary, 12, North Terrace, Adelaide	Contract Practice Appointments at Renmark Contract Practice Appointments in South Australia
WESTERN AUSTRALIA: Honorary Secretary, Saint George's Terrace, Perth	All Contract Practice Appointments in Western Australia
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington	Friendly Society Lodges, Wellington, New Zealand

Diary for the Month.

JAN. 8.—New South Wales Branch, B.M.A.: Council (Quarterly).
JAN. 9.—Tasmanian Branch, B.M.A.: Branch.
JAN. 11.—Queensland Branch, B.M.A.: Council.
JAN. 11.—South Australian Branch, B.M.A.: Council.
JAN. 15.—New South Wales Branch, B.M.A.: Ethics Committee.
JAN. 22.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
JAN. 23.—Victorian Branch, B.M.A.: Council.
JAN. 24.—Brisbane Hospital for Sick Children: Clinical Meeting.
JAN. 25.—Queensland Branch, B.M.A.: Council.
JAN. 29.—New South Wales Branch, B.M.A.: Organization and Science Committee; Medical Politics Committee.
FEB. 1.—Queensland Branch, B.M.A.: Branch.
FEB. 6.—Victorian Branch, B.M.A.: Presentation of Balance Sheets, 1923.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, B.M.A. Building, 30-34, Elizabeth Street, Sydney. (Telephone: B. 4635.)

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